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Interviewer's Aid for VD

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U. S. Navy

Interviewer's Aid

for

VD

Contact Investigation



U. S. BUREAU OF MEDICINE AND SURGERY



NAVMED P-1285 (5/46)

MEDICAL DEPARTMENT

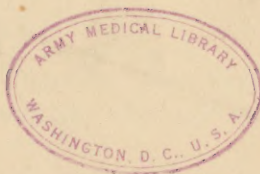
U. S. Navy

Interviewer's Aid

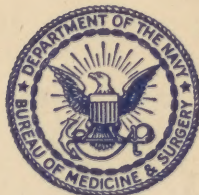
for

VD

Contact Investigation



U.S. BUREAU OF MEDICINE AND SURGERY



NAVMED P-1288 (6/48)

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Prepared by
Venereal Disease Control Section
Preventive Medicine Division
Bureau of Medicine and Surgery
United States Navy
in collaboration with
United States Public Health Service and
Venereal Disease Education Institute
Raleigh, North Carolina

FOREWORD

The close association between war and the spread of venereal disease has been recognized from the very earliest times. Military forces have been ravaged by venereal diseases in times past to the point where their fighting strength was dissipated and the campaigns were lost. The armies and navies of the world have attempted to meet this challenge to their manpower in various ways, the majority of which were more or less unsuccessful until the advent of World Wars I and II. During these wars, for the first time, the rate of venereal infection was lowered instead of skyrocketing as it had always done before. The Navy rate in World War I went down to 70 per 1,000 per year. During World War II, it went to 28—the lowest since our recorded figures began in 1873. Subsequent to both wars, the rates climbed upward again following the pattern which has followed the conclusion of all wars, in every country of the world affected by them.

One of the most important developments in venereal disease control has been the institution of the uniform Navy venereal disease contact reporting system under the heading of "Contact Investigation." Reporting of contacts of venereal disease patients to cognizant health departments brings under treatment those individuals who are immediately responsible for the spread of venereal disease.

The Navy's responsibility in contact reporting is to elicit all possible information which will assist in identifying and locating contacts and to furnish such information via the venereal disease contact report to epidemiological investigators of State and city health departments in order that the spread of infection may be cut short.

The opportunity of re-educating the venereal disease patient in the nature and prevention of venereal disease is at its maximum in the man to man relationship of the contact interview.

When all the contact information is elicited and when the patient's ignorance and misconceptions about venereal disease and their prevention have been cleared away the contact interviewer can consider that his work has been well done and that he has made a significant contribution to the reduction of venereal disease in the Navy and in the country.

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Part I

INTRODUCTION

World War II ended in victory for the Allies just 7 years after it began. But another type of war, started almost 500 years ago, is still being waged * * * and the enemy is still unbeaten! It is the war of science against one of man's bitterest foes—the venereal diseases. For despite recent improved technics of diagnosis, treatment, and control, VD is today one of the most serious medical problems in military forces.

Wartime and postwar social upheavals are partly responsible for this situation. Sexual promiscuity during and after a war always increases opportunity for the spread of venereal diseases. The last war was no exception. New admission rates for venereal disease in the armed forces have risen to a point where military authorities and the public in general are expressing alarm.

The problem in the military venereal disease control effort has shifted because of scientific advances. The facilities, the drugs, and the knowledge are now available with which to banish forever the venereal disease from our midst. But, unless infected cases are located and treated, the control program breaks down. The simple fact is that out of every 10 persons who have VD—ONLY ABOUT 3 PERSONS are reported as found and treated. Obviously, the great task now is one of uncovering these “undiscovered” cases and bringing them to treatment.

That is the purpose of this INTERVIEWER'S AID, to show how you can aid the VD control program by helping to locate all cases in the chain of infection and by providing infected patients with educational information designed to prevent re-infection. The INTERVIEWER'S AID is divided into two parts. Material in part I is intended for training contact interviewers, both beginners and those already engaged in the work. Part II of the INTERVIEWER'S AID, which consists of a set of

visual aids for education of the VD patient, is to be used as supplementary material for the contact interview and re-education of the patient.

History of Public Attitudes Toward VD

Unlike most other communicable diseases, VD for many years has worked undercover simply because a false modesty has kept people from facing the facts. Almost everyone can remember when it was considered impolite to use the words “syphilis,” “gonorrhea,” and “venereal disease” in public. So great was the shame attached to these diseases that many doctors often hesitated to treat them, fearing possible injury to their professional prestige.

Regardless of this false sense of pride, venereal diseases continued to infect all classes of society. Rich and poor, young and old, black and white—none were immune from these infections which killed some and ruined the lives of thousands of others.

Because of the refusal to face the facts about the cause, effect, and cure of VD, many infected persons were not diagnosed and treated, or they resorted to drugstore cures or treatment by quacks. As a result, many children were born dead or with malformation resulting from congenital syphilis. Others were blinded through infection of the eye with gonococci during childbirth. Venereal diseases accounted for a large percentage of insanity, paralysis, heart disease, and lifetime cripples.

Despite all this human misery and suffering, there was apparently little interest in the venereal disease problem until 1936. In that year Surgeon General Thomas Parran of the United States Public Health Service wrote an article entitled, “Why Don't We Stamp Out Syphilis,” which was published in *The Reader's Digest* and was followed

by a torrent of public interest. Almost overnight the false sense of modesty that had shrouded the disease in a cloak of mystery for years was torn away, and the problem was at last brought out into the open. From that time on the public became truly aware of the problem and wanted to know the facts about VD so that it could be discovered and controlled.

What You Should Know About VD

As a member of the Medical Department you can be of tremendous help in case finding. But before you undertake to help others with their problem, you must know something yourself about the venereal diseases, their causes, effect, cure, spread, and prevention.

The origin of venereal disease is veiled in mystery. Few historians agree on the exact beginning of either syphilis or gonorrhea—the most common venereal diseases. Undoubtedly, gonorrhea was known centuries before the time of Christ. Some authorities believe that the natives of the West Indies infected Columbus' men with syphilis and that they in turn carried the disease back to Spain. From there, aided by invading armies, it spread rapidly throughout Europe. Each country blamed the other for spreading the infection. Thus, syphilis, or the great pox, as it was called, became known as the "Spanish Disease," the "French Disease," and the "Neapolitan Disease."

There are five venereal diseases—syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum. All are caused by a specific germ and most are highly contagious. Because they are most common, syphilis and gonorrhea are the greatest problem. Owing to better hygienic measures in use today, chancroid, a disease that thrives on filth and uncleanness, is far less prevalent now than formerly. Too, much early syphilis, once diagnosed as chancroid, because of recent improved methods of diagnosis, is now properly recognized.

Both granuloma inguinale and lymphogranuloma venereum, though world wide in distribution, are more common in tropical climates. These diseases, which often result in serious degeneration of genitals and adjacent parts, most frequently occur among negroes.

How VD Is Spread

Venereal diseases are spread from person to person almost entirely by sexual intercourse. The chances of contracting it increase tremendously when an individual changes sexual partners frequently (promiscuous relations), or when the individual's sexual partner is promiscuous. If every man and woman remained faithful to one wife or husband, there would be no venereal disease.

Individuals differ in their sexual habits. Some are monogamous (a single mate), while others have extremely high degrees of promiscuity. It should be remembered that while loyalty to a single mate is the best development of a healthy, well-rounded, mature, civilized male, and in all respects produces the highest degree of bodily, mental, and spiritual health; at the same time, the contact interviewer must be aware of the actual sexual performance of the man before him and show no shock or disapproval if he wishes to do his job.

Prior to World War II, the commercial prostitute accounted for the majority of the infections in the Navy. But during the war and in the post-war period, the young highly promiscuous girls, often called "victory girls," "B girls," "pick-ups," and "amateur prostitutes," were responsible for the greater percentage of infections in the Navy as well as all other military services.

An increasing number of prostitutes, both clandestine and commercial, are again being given as the source of venereal infection of naval personnel. Prostitutes, all of whom have had one or more of the venereal diseases, are at all times a potential source of infection even though they may not themselves be infected. Their tremendous number of customers each day makes it impossible for them to keep free of infections, and during sexual intercourse, it is possible for a man to pick up an infection from a prostitute infected only a few minutes before.

Eight out of ten prostitutes arrested in a large city had a positive blood test, and all had gonorrhea at one time or another.

Venereal diseases are rarely spread by means other than sexual intercourse. Some individuals, who feel guilty of promiscuous sexual relations and want to hide their sexual escapades, often blame objects such as toilet seats, towels, personal articles, and dishes as the source of their infection.

Except for remote possibilities no venereal disease is transmitted in such a manner. Since germs transmitting venereal diseases cannot live long away from the human body they are usually transferred from person to person and from the mucous surfaces (such as the genitals, mouth, and eyes) of infected persons to the mucous surfaces of another person.

Although it is a rarity, medical records indicate that nurses, doctors, and laboratory technicians have become accidentally infected through coming in contact with syphilitic infections when examining or treating VD patients or when handling laboratory specimens. Gonorrhea has been transmitted from person to person, usually young children, in hospitals by rectal thermometers which have been improperly sterilized after use.

Incubation Period

In order for a person to become infected it is necessary for the germ causing one of the diseases to enter the body. For a time after the germ enters the body there are no outward symptoms of the disease. But eventually, in a few days or weeks, certain symptoms appear. This period of development within the body is known as the *incubation period*. The incubation period varies for each disease and varies from one person to another.

	Average	Minimum	Maximum
Syphilis.....	3 weeks or longer	10 days.....	90 days or longer.
Gonorrhea.....	3 to 5 days.....	1 to 2 days.....	2 weeks.
Chancreoid.....	2 to 12 days.....		
Granuloma inguinale.....	Variable.....	8 days.....	12 weeks.
Lymphogranuloma venereum.	7 to 12 days.....	5 days.....	30 days.

Infectious and Infected

All the venereal diseases are communicable and anyone with a venereal disease is *infected*, and except for syphilis, all are *infectious* until “cured.” Syphilis is infectious until (1) treatment has been given for a certain length of time and there are no open lesions, or (2) the disease has been in the body for some time without treatment, usually 6 months to 2 years.

Exposure Periods

The exposure period is composed of two parts, the time during which the patient may have been exposed and the time during which he may have

exposed others. The exposure period is of a different length for each disease and is shown in the chart on page 19.

Syphilis

Syphilis is caused by a germ, the spirochete *Treponema pallidum*. The incubation period is variable (10 to 90 days). The first sore of primary or early syphilis appears at the site of entrance of the spirochete into the body of the victim. This sore is called a chancre (pronounced “shanker”). The chancre may last from 1 to 3 weeks and may heal with or without treatment. Diagnosis is made at this stage by finding the spirochete in the darkfield microscopic examinations of serum obtained from the chancre. Blood test for syphilis will be negative at this time, if the chancre has only recently developed.

Secondary lesions of early syphilis may appear in the form of a macular (spotty) skin eruption (often faint copper colored), accompanied by enlarged lymph glands, within a period of from 3 to 8 weeks or longer after appearance of the initial lesion. There may also be papules (raised bumps), sore throat, with patches in the mouth, patchy falling of hair, and headache. These secondary lesions usually disappear within about 3 weeks. If untreated, they may reappear one or more times as relapses. Diagnosis may be made from early lesions by darkfield examinations, but these may be negative during the stages of secondary lesions. Moist secondary lesions should always be examined by darkfield. The blood serological test for syphilis is almost always positive during this stage.

Late syphilis (formerly called tertiary syphilis) follows secondary syphilis after a period of quiescence for from 1 to 20 years. Manifestations of this stage may be blindness (primary optic atrophy), insanity (paresis), paralysis, vascular disease (disease of the heart and/or blood vessels), loss of position sense, charcot joints, or destructive ulcers of the skin or mucous membranes. Dark-field examination of any lesions in this stage are almost always negative; blood test is usually positive but may be doubtful or negative. The longer the duration the greater likelihood that the serological tests will become negative spontaneously. The spinal-fluid examination may or may not be positive. If it is positive the patient has central nervous system syphilis. This may go on for years before symptoms develop. Some patients, however, may have symptoms of central

nervous-system syphilis without positive spinal-fluid findings.

Gonorrhea

Gonorrhea, the next important venereal disease after syphilis, is caused by bacteria described as Gram negative intracellular diplococci and known as *Neisseria gonorrhea* or the gonococcus. The incubation period is from 3 to 10 days, but may be prolonged. This organism has an affinity for, and grows in, columnar epithelium which *lines the urethra*. The symptoms are a purulent (creamy) yellow discharge from the urethra in the male (may only be mucoid at first) and a purulent yellow discharge from the cervix and/or urethra in the female. The discharge may be prolonged without treatment or without proper treatment; however, with penicillin treatment it disappears in one day or less, and with sulfa drugs somewhat more slowly. Diagnosis is made by microscopical examinations of smears, and by cultures. Smears are made from the discharge and stained with Gram's staining technic. Bacteriological cultures are necessary to confirm diagnoses in certain instances and should always be used as one of the criteria for cure in both male and female. Four negative cultures at weekly intervals are recommended following treatment. The possibility of reinfection should be considered whenever a positive culture follows a negative one. A follow-up should include monthly blood tests for syphilis for 4 months. The test at 4 months is the most essential one.

Complications of gonorrhea are posterior urethritis, periurethral abscess, prostatitis, and epididymitis in the male, and Bartholinitis, acute inflammatory disease (salpingitis, oophoritis) in the female. Arthritis and sterility may occur. In rare instances heart disease or septicemia complicates the disease and usually ends fatally. The disease is infectious as long as gonococci are har-

bored in the prostate, cervical, or other genital glands.

Chancroid

The less common venereal diseases include chancroid (chancre-like). Chancroid is characterized by a local rapidly developing, painful dirty sore. It is caused by the Ducrey bacillus (*Hemophilus ducreyi*) and is diagnosed by direct microscopic examination of stained smears from the lesion, by cultures, or by a skin test (Ito-Reenstierna test). The incubation period is short (3 to 5 days), but may vary between 2 and 12 days. The lesion is very painful and is accompanied by a painful and tender swelling of the regional lymph nodes.

Lymphogranuloma Venereum

Lymphogranuloma venereum is caused by a virus and sometimes starts with a small transitory primary sore (usually on the penis or around genitalia). This is found in only about one-third of the cases. It is a disease of the lymph nodes and channels, and usually shows bubo formation. In neglected cases, it may cause rectal stricture (in female), and genital elephantiasis. Diagnosis is made by the Frei test (a skin test). The incubation period varies from 10 to 30 days.

Granuloma Inguinale

Granuloma inguinale is caused by a germ *Donovania granulomatis* (Donovan bodies). This disease begins with a small pimple or painless ulcer after an incubation period from 8 days to 12 weeks. It starts as a vesicle, papule, or nodule which develops and spreads by continuity (daughter lesion developing near larger lesions), and may involve the inguinal areas. This disease is not accompanied by bubo formations. The disease may last for years, during which it may eat away extensive areas of flesh and skin and cause elephantiasis. It is difficult to cure in many cases.

Venereal Disease Summary Chart

	Syphilis	Gonorrhea	Chancroid	Granuloma inguinale	Lymphogranuloma venereum
Common names or synonyms.	"Syph." "pox." "lues." "old Joe," "bad blood," "hard chancre," "elchancre."	"Clap," "dose," "strain," "the drip," "running," "gleet," "G.C."	"Soft chancre," "bubo," "hair cut."	"Ulcerative granuloma of pudenda."	"Lymphopathia venereum"; "lymphogranuloma inguinale."
Germ causing disease (etiology).	<i>Treponema pallidum</i> (popular term, "spirochete").	<i>Neisseria gonorrhea</i> (gonococcus).	Ducrey bacillus.	Donovan bodies.	A specific filterable virus.
Method of spread.	(1) Usually sexual intercourse. (2) Kissing and fondling. (3) Prenatal (mother to fetus).	Sexual intercourse and ophthalmia infection at birth.	Sexual intercourse.	Sexual intercourse; direct contact by skin and mucous membrane.	Sexual intercourse; direct contact by skin and mucous membrane.
Incubation period.	10 to 90 days.	3 to 14 days.	2 to 12 days.	2 to 12 weeks.	10 to 30 days.
Clinical signs and symptoms.	<i>Early:</i> Primary—chancre. Secondary—rash, mucous patches, sore throat, headaches, fever, etc. <i>Latent</i> (early latent; late latent) (seropositive only). No active manifestations. <i>Late</i> (tertiary): Active manifestations: Cardiovascular, neurosyphilis, gumma, ocular, osseous, visceral. <i>Mucocutaneous relapse:</i> Recurrence of infections lesions after disappearance of secondary lesions.	<i>Male:</i> Purulent urethral discharge; burning on urination; pain (sometimes); inflammation and swelling. <i>Female:</i> Possibly no symptoms; vaginal discharges; pain in abdomen (when salpingitis occurs).	Frequent multiple or single, painful, tender, rapidly growing, nonindurated ulceration, with undermined border ragged edge, and dirty gray wet base.	Beefy, red, granular, shiny, well defined, granulating ulcer, slowly growing but progressive.	Frequent absent history or presence of a pimple or small ulceration in about one-third of the cases; bubos; rectal stricture in late stage in female.
Diagnosis.	Darkfield examination. Serological tests. Case history. Clinical signs and symptoms. X-ray.	Smears. Cultures. Case history. Clinical signs and symptoms.	Darkfield (to exclude syphilis). Skin tests (Ito-Reensterna). Presence of Ducrey bacillus. Case history. Clinical signs and symptoms.	Darkfield (to exclude syphilis). Case history. Clinical signs and symptoms. Presence of Donovan bodies.	Darkfield (to exclude syphilis). Case history. Clinical signs and symptoms. Frei skin test.
Treatment.	Penicillin. Arsenicals. Heavy metals (bismuth). Combination of arsenicals and heavy metals, or all three.	Penicillin. Sulfonamides. Combination of penicillin and sulfonamides.	Sulfonamides. Cleanliness. Hot soaks.	Streptomycin. Tartar emetic, fuadin, etc., intravenously. Cleanliness. Surgery. X-ray.	Sulfonamides. Dilatation of rectal stricture.

VENEREAL DISEASE AND THE NAVY

The venereal diseases are considered a problem to the Navy because of:

- (a) Time lost from duty.
- (b) Reduced efficiency of the man.
- (c) Break-down of teamwork—loss of efficiency of the organization.
- (d) Cost of medical treatment and hospitalization.
- (e) Permanent damage to individuals.
- (f) Ultimate effect on individual, family, and Nation.

During World War II over 3,000,000 man-days were lost to the Navy through venereal disease. Gonorrhea alone accounted for a total of 2,194,010 lost man-days. An average of over 2,100 men were constantly on the sick list for venereal disease infections throughout this period. The number of man-hours lost through break-down of teamwork and efficiency is hard to compute because there are other aggravating factors, of which venereal disease is only a part.

Among the leading causes of loss of manpower in the Navy, the venereal diseases are outstanding, having ranked first or second among contributors to noneffective ratios (man-days lost) for 38 years out of the 46-year period, 1900–1945, inclusive.

Noneffective ratios, Navy and Marine Corps, first 5 ranks, by diagnostic class, 1900–1945

Diagnostic class	Number of years in rank					
	Total	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Venereal disease (class XII)-----	43	25	13	2	1	2

As far as any disease goes, gonorrhea probably has always been a factor of far greater importance to the Navy as a cause of loss of manpower and as an item of expense than any other single disease. For example, in 1940 there were 174,305 sick days due to gonorrhea alone. This is almost five times the number of sick days due to tuberculosis, over

37 times that caused by malaria and more than 10 times that of all forms of pneumonia. The venereal diseases as a whole contributed more sick days than all accidents, injuries, and poisonings in the Navy in 1940, yet the 1940 rate for the venereal disease was 15 percent less than the median rate for the previous 9 years. During that year there were 69 men invalidated from the service on account of venereal diseases—many of them permanently disabled and requiring domiciliary care the rest of their lives.

An estimate of the costs of venereal disease to the Navy in the year 1945 could be made as follows:

Pay to men while on sick list:

129,205 cases, average 5.35 sick days each. \$3, 864, 832
504,302 estimated hospital days, at \$4.75
per day----- 2, 435, 783

Subsistence to men while in dispensaries:

186,523 patient-days----- 127, 563

Total cost of venereal disease----- \$6, 428, 178

Cost of dispensary treatment, drugs, salaries, and cost of pensions are in addition to above. Eighty-eight neurosyphilitics were surveyed from the service, and the Veterans' Administration estimates each such case in his lifetime will cost the taxpayer \$40,000. This would come to, eventually, approximately \$3,500,000 for Navy cases surveyed in 1945.

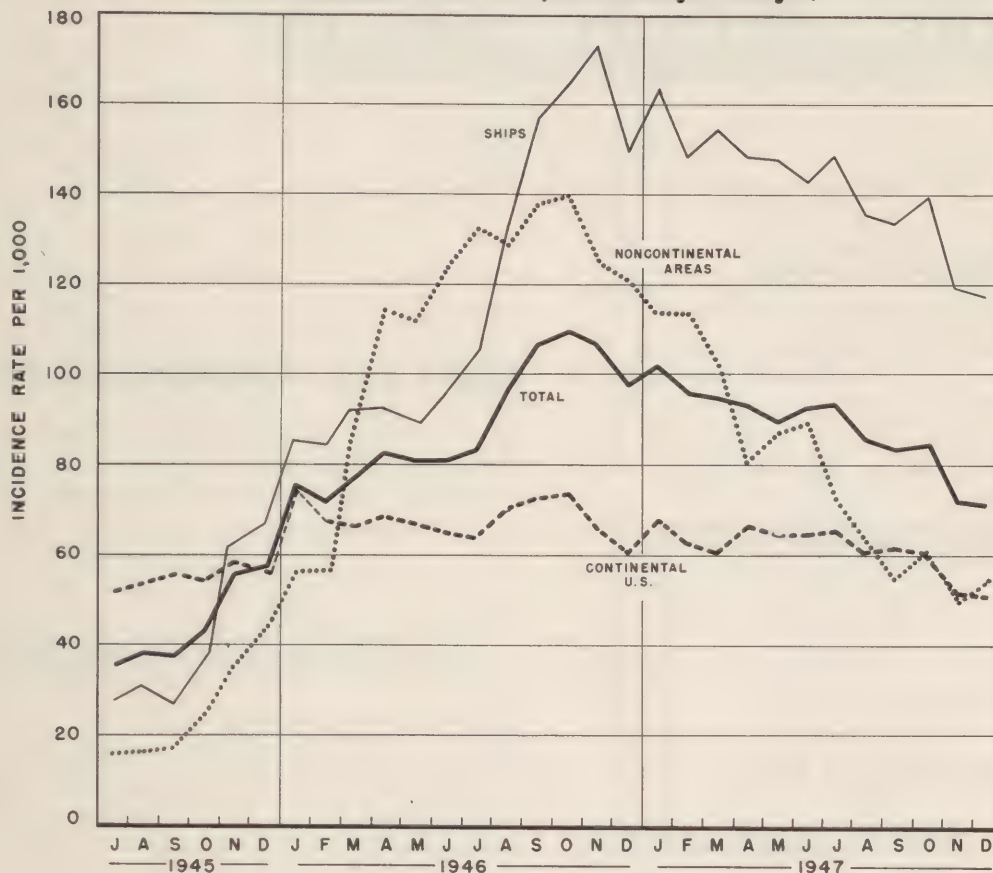
The rate of 71 admissions per 1,000 strength for December 1947 does not necessarily mean that 71 men per 1,000 would in a year get a venereal disease, since many men are admitted several times in 1 year. One man had a record of 10 admissions, 9 for gonorrhea and 1 for syphilis during 1 year. The incidence of the venereal disease among military personnel is strongly influenced by the prevalence of these diseases among the civilian population, wherever our men are stationed.

Over 3,000,000 people in the United States have syphilis, according to the United States Public

VENEREAL DISEASES

TOTAL - CONTINENTAL U.S. - NONCONTINENTAL AREAS - SHIPS
U.S. NAVY AND MARINE CORPS

Monthly, Jul 1945 - Dec 1947
(Annual Incidence Rate Per 1,000 Average Strength)



Prepared by Medical Statistics Division, BuMed

Health Service, and some 250,000 more contract the disease each year. Of this latter figure only 95,000 persons are reported as having been found and treated in the primary or secondary stages of syphilis. Approximately 1,300,000 contract gonorrhea yearly, but only 375,000 of these are reported as treated each year.

For many years the Navy and Marine Corps considered the acquiring of a venereal disease the result of a person's own misconduct and he was penalized by pay deductions and making up time lost while he was on the sick list. This led to a

serious amount of concealment, self-treatment, and treatment by quacks. As a result complications piled up, and loss of efficiency was actually increased.

In September 1944 the misconduct status of venereal disease was abolished except where concealment was attempted or where regulations were violated (act of 78th Cong., Public Law 439). With punitive measures removed, practically all infected persons report to the Navy medical officer rather than seek self-treatment or medical aid outside the Navy.

WEAPONS AGAINST VD

EDUCATION

Scientific facts in simple terms.

Continence stressed as the only sure way of avoiding VD.

Facts about VD, its cause, prevention, spread, and cure.

MEDICAL TREATMENT

Application of modern methods of diagnosis and treatment.

Adequate follow-up for evidence of relapse or making of other diseases.

PROPHYLAXIS

Individual prophylaxis (pro-tube) and station facilities.

Necessity for precautions, prompt reporting.

Presented as stop gap measures since some men despite good family background and moral teachings will risk infection.

CONTACT INVESTIGATION

Identification of contact, place of exposure and procurement as first step in bringing to treatment the million new cases of VD each year which are not reported or treated.

OFF-STATION ACTION

Repression of prostitution.

Cooperation by military forces with other governmental agencies, Public Health Service, law-enforcement officers, social welfare, and civic authorities.

CONTACT INVESTIGATION:
Navy's No. 1 Weapon in assisting public health and civil authorities in reducing the reservoir of infection in civilian communities' most direct man-to-man technic of uncovering unreported VD cases.

Education

Nearly every venereal disease infection in the Navy reflects a failure at some point in the control program. This failure is principally in the educational process directed first at avoidance of exposure (continence) and second at prophylaxis.

Ignorance of the facts of sex hygiene and venereal disease, their significance to the individual and the Navy, and the technic of prophylaxis accounts for many current infections. Indoctrination of all personnel, therefore, is a continuing responsibility of every member of the medical department.

A large proportion of the enlisted personnel (as much as 80 percent at times) are under 20 years of age, therefore their youth and background must be appreciated in applying educational procedures.

The moral code of the bulk of the personnel of the Navy has been well established through environment, association and training in the home, school and church. The influence of unfavorable group pressure on certain individuals and the opportunity for exposure should be taken into consideration when planning an educational program. Every effort should be made to reinforce moral values, self-discipline, and esprit de corps in the individual.

While education is the first weapon in venereal disease control, it should be recognized that giving a lecture on morality along with the contact interview will completely destroy the rapport and confidence which the patient must feel toward the interviewer if he is to give complete contact information.

If any education is to be worked into the contact interview, it should be limited to the facts on how venereal disease is spread through the community, and how contact tracing will help in guarding the health of both the patient himself, and many other people in the future.

Preaching should be avoided at all costs, and any attempts to inspire the patient to adopt a better moral standard should be withheld until every possible bit of contact information has been obtained.

Even then the interviewer would be on safest grounds if he left the moral indoctrination to other hands and to other occasions.

Medical Treatment

The medical officer's functions and responsibilities in this field are obvious. Early diagnosis and adequate treatment is another of the weapons in venereal disease control. The objective of early diagnosis and treatment is:

- (1) To detect early signs and symptoms of disease.

- (2) To cure the patient with the least possible loss of time from duty.

- (3) To prevent complications or cure complications when they do exist.

- (4) To render the patient noninfectious to others in the shortest possible time.

Every ship and station includes within its organization a medical department, varying in comprehensiveness from hospitals and large dispensaries to the small sick bay on small ships with hospitalmen on independent duty. Each such activity is equipped with or has access to facilities for diagnosis and treatment. The specific responsibilities for medical officers and hospitalmen are defined by provisions of the Manual of the Medical Department, directives from the Bureau of Medicine and Surgery, and subordinate command directives. Determination of the precise procedures in diagnosis and therapy in each case is the professional responsibility of the medical officer.

Off-Station Action

Considered of great importance in the endeavor to bring venereal disease under control are those public and private agencies which seek to adjust environmental circumstances to prevent venereal infection both in the civilian and military communities. The armed forces are parties to a specific agreement, known as the Eight-Point Agreement, which is the basis for venereal disease control both in the Military Establishment and civilian communities. Paragraphs 3 and 6 obligate the armed forces to report contacts of venereal disease cases to civilian authorities and to furnish information about places of exposure, and in paragraph 4, the civilian authorities have agreed to notify the armed forces of exposures of their personnel.

The New Eight-Point Agreement of 1946

An agreement on measures for the control of venereal diseases, April 1946

It is recognized that the following services should be developed by State and local health and police authorities in cooperation with the United States Public Health Service and the Social Protection Division of the Federal Security Agency, the United States Treasury Department, the United States Army, the United States Navy and interested voluntary organizations:

1. Early diagnosis and adequate treatment by the Army, Navy, and Coast Guard of military personnel infected with venereal diseases.

2. Health departments will assure the adequacy of case finding, diagnostic treatment and case holding procedures for the civilian population.

3. When authentic information can be obtained as to the probable source of venereal disease infection of military personnel, the facts will be reported by officers of the Army, Navy, or Coast Guard to State or local health authorities. If additional authentic information is available as to contacts had by infected military personnel during the communicable stage, this should also be reported.

4. All contacts of military personnel with infected civilians should be reported to appropriate officers of the Army, Navy, or Coast Guard by local or State health officers.

5. Recalcitrant infected persons with venereal diseases should be forcibly isolated during the period of communicability. In civilian populations it is a duty of local health

authorities to obtain any needed assistance of the local police authorities in enforcing such isolation.

6. Opportunities for contacts with persons reasonably suspected of being infected with venereal disease should be decreased as far as possible. The local police department is responsible for the repression of commercialized and clandestine prostitution. The local health departments, the State health departments, the United States Public Health Service, the Social Protection Division, the Army, Navy, and Coast Guard will cooperate with local police authorities in repressing prostitution. Local police departments should be provided with such information relative to places of procurement, and exposure, as is necessary to carrying out their responsibilities.

7. An aggressive continuous program of education should be carried on both among military personnel and the civilian population regarding the dangers of venereal diseases, methods of preventing venereal infections, and the steps which should be taken if a person suspects that he is infected.

8. State and Territorial health officers, the Federal Security Agency, the Treasury Department, the Army and Navy, all desire the assistance of representatives of the American Social Hygiene Association of Affiliated social hygiene societies or other voluntary welfare organizations or groups in developing and stimulating public support for the above measures.

ROBERT P. PATTERSON,
Secretary of War.

JAMES FORRESTAL,
Secretary of the Navy.

FRED M. VINSON,
Secretary of the Treasury.

WATSON B. MILLER,
Federal Security Administrator.

I. C. RIGGIN, M. D.,
Association of State and Territorial Health Officers.

Prophylaxis

When talking with a man who has just acquired a venereal disease, the contact interviewer should assume that the patient failed in one way or another to take proper prophylaxis during or after exposure. He should make sure the patient understands the procedures which will effectively keep him from getting venereal disease again. Most of the patient's previous education on this subject has been a mass effort, and there may be some crucial point he does not understand. The interviewer must be careful to cut this short if it is obviously boring, or he will lose all his influence with the patient. None of this part of reeducation should start until all contacts are named.

Continence.—The patient should be aware that this is the surest method. He may need instructions that intercourse is not necessary to manly vigor, that wet dreams are physiological and not weakening, that desire is easier to control before it is aroused. The interviewer need not admit it to the patient but if his patient is the type who is not going to be swayed by the interviewer's teaching in this line, the interviewer should drop it.

Mechanical prophylaxis.—The patient should know:

(a) The condom is the surest method.

(b) More reliance can be placed on those for sale at naval facilities.

(c) It should be put on before any contact is made.

(d) It should be rolled on, holding a short space at the tip compressed.

(e) It should be removed carefully, with one swift motion, turning it inside out as it comes off.

(f) Washing with soap is most important. The tip and shaft of the penis should have stayed clean but germs can be at the base, in the hairy parts and on the scrotum and inside of thighs.

(g) All parts should be washed thoroughly with plenty of soap and water, taking care not to spread germs with a dirty cloth from dirty to clean areas. Remember the hands may also carry germs. Use plenty of soap.

(h) Urinate. If there was any contact with the urethra while removing the condom, urinate before washing.

Chemical prophylaxis.—

(a) Time is an essential factor, the sooner the better.

(b) The pro-tube contains antiseptic and should be used as directed, immediately after exposure.

(c) Urinate first.

(d) Wash thoroughly with soap and water, if possible; particularly under the foreskin.

(e) In any event, dry thoroughly.

(f) Then apply the chemical exactly as directed, part in the channel, the rest on the head, shaft, and nearby parts. Take plenty of time to rub it in.

Station prophylaxis.—If done under supervision of a conscientious corpsman, this is better than a poorly done individual prophylaxis. It should be required of men who have been recently exposed or who are too intoxicated to give reliable answers.

One schedule of station prophylaxis is as follows:

(a) Urinate.

(b) Wash thoroughly with soap (green soap) and water.

(c) Inject one-half syringeful of 1 percent strong silver protein (protargol) or 10 percent mild silver protein (argyrol, silvol) into the channel gently and allow it to run out. Then the other half is injected and held 5 minutes.

(d) All exposed areas including penis, scrotum, pubic region, lower abdomen, and inner surface of thighs, are liberally anointed with 33 percent calomel in lanolin. This should be rubbed in well for 10 minutes.

Station prophylaxis is almost 100 percent effective if taken within 2 hours and becomes rapidly less effective with passage of time.

Venereal Disease Contact Investigation

One of the most important mechanisms which directly attack the chain of spread of venereal disease is *contact investigation*. This requires four operations, two of which are the responsibility of the Medical Department of the Navy and two of which are the responsibility of the civilian health departments. For success, close liaison between military and civilian authorities is necessary.

Contact Investigation is Considered as Comprising

1. *The patient contact and reeducation interview.*—This is a serious conversation between the patient and the medical officer or enlisted interviewer. The purpose of this interview is twofold, first it seeks to identify the sexual contacts and second to reeducate the patient in an effort to prevent further infections. The primary purpose is accurate identification of all contacts with whom the patient has had sexual relations during the incubation period of the disease and up to the time of the interview. The other purpose is to reeducate the patient in an effort to prevent him from becoming infected again and to explain the patient's disease, treatment regimen, clarify his misconceptions of venereal disease, need for adequate follow-up with serological examinations, and provide the missing information on prophylaxis.

2. *Contact reporting.*—This is the second element of contact investigation and is done by means of a simplified form, NAVMED-171 (Venereal Disease Contact Report). Instructions for the use and routing of this form to civilian agencies are printed on the form itself and are also contained in supplemental BuMed directives. The primary function of the contact form is to identify all sex contacts. The basic principle in contact reporting is to transmit the completed forms to proper civilian authorities with all possible speed in order to find and make noninfectious all possible transmitters of VD. A second and almost equally important function is to call the attention of civilian authorities to places, conditions, and persons that facilitate the spread of VD.

3. *Contact location* is a function of the civilian health departments. Data furnished through NAVMED-171 is used by field workers to locate alleged contacts and to persuade them to be examined. This is done with tact and in such a

way as to avoid embarrassing the contact, or disclosing the informant's identity.

4. *Contact disposition* is also a civilian operation. It involves the medical examination of the contact, establishment of diagnosis, and treatment if necessary. This is the step that breaks the chain of further spread. Finally, the results of the investigation are reported back to the Navy by means of NAVMED-171.

The Chain of Infection

From the point of view of the civilian public health authorities, contact investigation tends to bring more persons under treatment per dollar expended than all the other devices combined, such as blood tests, premarital, and prenatal examination, etc. It is especially aimed at decreasing the reservoir of active infection.

It tends also to focus attention on those places where contacts are encountered, and places of exposure, thus providing a factual guide for civilian law-enforcement agencies to take action against prostitution and other activities which spread venereal disease. The contact reports further provide an index as to the social habits of both naval personnel and civilian groups. They directly draw attention to points where emphasis is needed and aid materially in the efficient administration of venereal disease control both in the military service and civilian communities.

The Interviewer

The ideal contact interviewer is one who takes an interest in the patient and in venereal disease control. Hospital corpsmen trained in venereal disease contact interviewing have been found to be the best interviewers. While a college diploma or a professional degree are not criteria for interviewing success, a good education is desirable.

It is essential, however, that the interviewer have good common sense and the ability to deal with people. If he expects to gain confidence and cooperation, he must sell himself to the patient, and must convince the patient of his genuine desire to help. He must like people and people must like him. He should be mature in understanding, sympathetic in viewpoint, have a good personal attitude toward sex and the venereal diseases, a good working knowledge of the variability of sex habits in different types of people, as well as a healthy adjusted sex life of his own. A

good interviewer must have a lively appreciation of life in the modern world.

He must possess a working knowledge of venereal disease, its prevention, diagnosis, treatment, and prognosis.

The interviewer must have a working knowledge of the administrative procedure for handling the contact reporting forms and procedure for routing. He should be familiar with the geography of the local community, its public health departments and how they function. He should be familiar with all Navy orders and directives relating to venereal disease control. The interviewers should have a comprehensive knowledge of the Navy venereal disease control program, liaison with other military, governmental, and civilian agencies in this field. He should be familiar with the recreational and welfare facilities in the communities. He should know whether, as in foreign areas, there is prostitution permitted. He should be familiar with the number and location of all prophylactic facilities in the area. Last, but not least, the interviewer should know the fundamentals of education, know how to lead the thoughts of his pupil to make his own sound conclusion.

The Setting

The setting, or place of interview, is vitally important in its effects upon the patient. The setting of the interview room determines first impressions, and it is extremely important that these be good. It is important that personnel working in and around VD patients bear in mind that the purpose of the contact interview is to break the chain of infection as well as treatment of venereal diseases, and that the success or failure of his efforts depends upon the way in which the patients are handled. It is the patient after all, who holds the key to success or failure in the whole control effort. The interviewer, working with the medical officer and the venereal disease control officer, should do all he can to promote a friendly attitude and to create an atmosphere favorable to a confidential interview.

The first and most important physical provision is *privacy*. The interviewer and his patient should be free from interruptions by other personnel. Nothing can do more to spoil an interview than an unexpected and unannounced entrance of some other person. A knock at the door has about the same effect. There should be no telephone in the interview room. The inter-

view room should harbor "no junk," but only the aids actually used in interviewing. There should be convenient space for VD literature which should be given at the close of an interview to all patients. Literature handed the patient during the interview can and often does distract attention. A file of all contact data should be kept in



The interview room—privacy and adequate visual aids and materials are of utmost importance.

the room readily accessible to the interviewer. Interview forms, and any other material used in the interview should be on hand at all times.

The Diagnostic Conference

Normally the first important contact the patient has is the diagnostic conference between the medical officer and the patient. The diagnostic conference takes place after the patient is admitted, examined, and the diagnosis established. At this time and stage, the patient is most open to suggestion. It is here that a good foundation can be laid for securing the cooperation and participation of the patient in the later contact investigation.

With patience and understanding of human nature the physician explains that:

- (1) The patient has an infectious disease and informs him of its nature, manifestations, etc.
- (2) He can be successfully treated.
- (3) He must exercise certain precautions to safeguard others.
- (4) He is obligated and it is to his own interest to aid in stopping the spread of disease by giving certain information concerning his contacts, both those who may have been the source and those to whom he may have passed on his infection during the incubation period.

A medical program for the patient is thus established and the groundwork laid for the contact and reeducation interview.

The Contact and Reeducation Interview

In itself the contact and reeducation interview represents a continuation of the previously estab-



Reeducation—explaining the cause and effect of disease.



Reeducation—explaining that each case comes from another case—need for locating the contacts to prevent further spread.

lished doctor-patient confidential relationship. It should be held as soon as possible after the diagnostic conference of the medical officer. Here the interviewer and the patient meet face to face in an effort to solve the problems of each on a common ground. The interviewer sees his problems in the light of his threefold responsibility: (1) To the infected individual as a patient; (2) to Navy VD control; and (3) to the health of the contacts and the community. The patient on his part, sees his problems primarily (1) in the light of his own infection, (2) his treatment, (3) his desire to get well, and (4) what will happen to the contacts named.

The initial contact interview of the patient with a venereal disease is twofold in purpose: To convey to the patient information concerning his disease, and to elicit from the patient information concerning his contacts.

The patient needs to understand the basic facts about the disease with which he is infected in order that he may cooperate in taking the treatment which has been prescribed for him. It is also essential to the prevention of subsequent infec-



Identification of contact—completion of Venereal Disease Contact Report, NavMed-171.

tions. If properly done, the educational interview equips the patient with the necessary information and with the desire to impart to his shipmates basic scientific facts about the disease for which he is being treated. The interviewer should never lose sight of the possibility of making each of his patients a good educator among his shipmates. Every patient receiving treatment should be dismissed as a "satisfied customer." If he goes out a "satisfied customer" knowing the truth about the disease for which he was treated, it is natural for him to impart this truth to some of his shipmates.

Epidemiology

The interviewer should seek to elicit from the patient names and accurate information concerning his contacts. Success in this part of the interview is proportional to the quality and success of impressing him with the value of contact tracing in preventing infections, both in himself and others. Certain principles and practices determine the success or failure of the interview.

CONTACT INTERVIEWING REQUIRES...

1. **FRIENDLY ATTITUDE:** Build up patient's confidence by sympathetic understanding of his problem. Put patient at ease.
2. **RIGHT WORDS:** Use simple terms understood by patient. Explain technical terms that must be used.
3. **LISTENING ABILITY:** Be a good listener. This breaks down interviewer-patient barrier.
4. **EDUCATION:** Know the facts about VD. Get them across to the patient so that he will not risk danger again.
5. **PRIVACY:** Conduct interview in clean, congenial, and private surroundings.
6. **CONTROL:** Keep interview moving. Check progress in terms of goals, step by step.

REMEMBER YOUR GOALS

*the key to a successful
contact interview . . .*

PATIENT MANAGEMENT

Considerate, friendly handling of patient is essential for . . . cooperation, contact identification.



Contact Identification
Patient Re-education

(1) Do not accuse or censure the patient about how he got the infection.

(2) Be sincere—it is impossible to convey an impression of sincerity when there is no sincerity.

(3) Seek to uncover hidden fears and allay them.

(4) By all means become a good listener; don't let the interview become a one-way affair. Begin with the easiest questions for the patient to answer. Keep him going.

(5) Undertake to increase, not lessen, the patient's self-respect. Praise him often for cooperation.

(6) Always use persuasion rather than attempt compulsion to gain patient's cooperation.

(7) Practice patience, infinite patience. Don't use third-degree methods.

(8) Deal with each patient as an individual, not just another patient; there are as many individual differences as there are patients.

When the interviewer and patient are comfortably seated within the privacy of the interview room, the interviewer should attempt shrewdly to size up the patient. No two patients react in exactly the same way, therefore, no set methods of approach can be specified. The interview should be geared to the interviewer's impression of the patient's state of mind. The introduction of some topic of mutual interest will usually draw the patient into conversation.

Once started, many patients will continue talking if they find an interested listener. Sometimes the patient will tell much of the information without asking, establishing an excellent foundation for proceeding with the interview. The interview should not be hurried. A few well-done interviews will produce more results than many hurried and ineffective interviews.

Some patients, unless they are repeaters, will enter the interview room upset, uneasy, or afraid, as a result of having learned that they are infected with syphilis, gonorrhea, or one of the minor venereal disease. It is impossible to interview such a patient until that patient has been reassured and his fears and uneasiness allayed. The interviewer's mannerisms and attitude can do much to reassure such a patient. Often the offer of a cigarette helps the interviewer gain the attention and confidence of such patients. Sympathy, kindness, and sincere interest in the patient usually lead to reassurance. Most patients can be reassured by treating their infection as just another communicable

disease that has unfortunately been contracted and which is definitely curable in a very short period of time.

This is a good point at which to get a line on how many different girls the patient may have had contact with during the exposure period. A few questions about marital status, how old he was when he first started having intercourse how often he had it, how many different girls in a week, month, or year, will guide the interviewer to elicit information about all the possible contacts.

The patient should be reminded that he is the only person who knows who the contacts are, and that the health—and perhaps the lives—of these persons depend upon his willingness to help them. *Assure the patient that any information which he reveals will be kept strictly confidential and that the persons whose names he reveals will never know who revealed them.* Regulations forbid the giving of the name (MMD 12B6.2). The interviewer should assure the patient that his only purpose in asking for this information is to give these people the same chance to be examined, and if found to be infected, the same chance to get well, which he himself is being afforded. To the uneasy man, some assurance that the contact will be approached tactfully and not embarrassed is helpful.

If the patient is really sold on the idea that he is becoming an important cog in the machine of venereal disease control he is likely to agree with the interviewer that WE must try to help those people. Most patients like this opportunity to cooperate in helping others. Insist that the patient is helping his shipmates or helping the contact, NOT TELLING ON THEM.

Without accurate information on the NavMed-171, it is hard for contact investigators to locate the contacts; remember the interview of the patient with venereal disease is twofold in purpose: TO GIVE TO THE PATIENT INFORMATION CONCERNING HIS DISEASE AND TO OBTAIN FROM THE PATIENT INFORMATION CONCERNING CONTACT, SO THAT THE CONTACT CAN BE FOUND, EXAMINED, AND TREATED IF INFECTED.

This HAS happened:

The hospitalman in the venereal disease ward calls John Doe to his desk, ruffles some papers in his hand, and says in a tired voice, "O. K. now, Doe, I've gotta get some dope on this form here. Where'd yuh gittit?"

John Doe mumbles something to the effect that he'd had a few too many and didn't remember too much about the whole situation.

The interviewer grunts "O. K., O. K." puts "UNKNOWN" in all the blank spaces of the Venereal Disease Contact Investigation Form, NavMed-171, where the word can be used, and dismisses John Doe.

The NavMed-171 is later signed routinely by a medical officer, clutters up the mails as it undergoes various distribution and, eventually copy "B" returns to the originating activity marked "Information insufficient to begin investigation."

This CAN happen:

Nickols, HM1, assigned by the SMO to handle all contact investigations approaches John Doe's bunk and says, "Morning Doe; will you come with me? Have a report here to make out." He leads Doe to his office, tells him to sit down, and in a conversational tone explains the nature of the report, the reason for it, and its importance both to his shipmates and to the civilian public at large.

Nickols has received occasional instructions from the SMO as to interview techniques and realizes the value of an individualistic approach.

John Doe had also been drinking at the time he had gotten his infection, but Nickol's conscientious questioning elicited the information that the girl was called Dolores, that he had met her at the 3-Star Cafe, and that he thought she had a mole on her left cheek. That information was recorded and in due time copy "B" was returned with the notation "Contact investigated and is now under treatment for early syphilis."

The ridiculous waste of time and effort as pictured in the case of the first John Doe is entirely unwarranted and will not occur on any station where a venereal disease educational and contact interviewing program is properly carried on.

Having set the stage, proceed with the interview—do not be abrupt in questioning and remember that the success of many an investigation depended upon one simple point of description such as the style of hair-do or a peculiar piece of jewelry worn. Take up one girl at a time, beginning with the most recent contact and working back to the beginning of the exposure period. DO NOT START with name and description, but place of encounter which is more easily recalled and told by the patient.

The following questions are suggested for use only where accurate names and addresses of contacts, bars, houses, etc., are not known by informant.

Place of Encounter

How did you meet the girl—previous acquaintance? Through another person? (Who?) Bellhop? Taxi driver? Civilian? Bartender?

Where did you meet her? Dance? Hotel? Bar? Street pick-up? Describe bar dancing?

Where was the place located? What city? What part of town? Downtown? Outskirts? What street? Near what street? (City map helpful.)

If not known, were you drinking? How did you get to town? Walk? Bus? Streetcar? Private car? (If patient states that he was drunk, remind him that he was not drunk when he left the station and by questioning him as to his method of getting into town, etc., many times the interviewer will get the information desired. Use maps of city or area to help patient recall.) At what street did you leave the bus or other vehicle?

When you got off the bus which way did you turn, right or left? (Draw sketch on contact report to guide investigator when address is vague.)

Did you go to this place right away or did you walk around?

When you entered this place (if a bar) was the bar itself on the right or left?

Anything unusual about the back bar? Was the bar itself well lighted, or was the lighting subdued? How many bartenders? Were waitresses employed? Did you sit at the bar or a booth? What kind of music? Juke box? Was there dancing?

Did you pick up this girl there or did you meet her before you went to this bar?

What do you know of usual rendezvous of contact or associates? Did the bartender seem to know her—which one?

Anyone know her? Use only such questions as will be needed in identifying the place and the girl.

Time of Encounter

As nearly as you can, state the exact time of day you met this girl. About what time? Morning? Afternoon? Evening? Date, or approximate. (This can be determined by pay day, leave, etc.) This information helps investigator

to ascertain what shift of bartenders, bellboys, hotel clerks, or taxi drivers is involved.

Personal Description of Contact

What was her name? What nickname did she use? Give a good description of her. How old? How tall? Weight? Race? Hair? Eyes?

Wear any particular ring, style of hair-do, make-up; nationality—shoe style—feet, big?

Did she wear a hat? A coat? Slacks, sport clothes, or suit? Clothing—fur trim—etc.

Did she wear glasses?

Describe scars and marks on her hands and face. Describe marks on her body such as operation scars, tattoos, birthmarks, etc., moles, warts, teeth, deaf and dumb, eyes don't match. Speech characteristics, swear, tell dirty jokes, or have any other peculiarity.

A supplemental form is useful in covering these points, use details only where needed in absence of full name and address. Sex, race, and age should always be given.

Place of Exposure

If you met her in a tavern or elsewhere, where did you take her? A hotel? To her apartment? To a rooming house?

If to a hotel, do you know the name of the hotel?

If name not known, describe the entrance to the hotel. Large or small? Large windows on both sides of door? Was the desk and clerk on the right or left side of lobby? Was the lobby upstairs or on the street floor? Was there an elevator or did you walk up? Lawn? Approach—left or right?

What was the number of the room—what floor was it on? Were the bellboys young or old? Bellboys' uniform?

If an apartment, was there an elevator or did you walk up? What floor? Which way did you turn upon leaving stairs or elevator? What side of hall?

If procured (brought to the patient's room) by a bellboy or other person, give description of the procurer.

Fee Paid

If pay, how much did you pay her?

Prophylaxis.—Type used and time interval between first exposure and chemical prophylaxis.

Background of the Contact

The background of the contact can also serve as an important factor in identification of contacts when other clues are missing. Apparently the patient during his meeting with the contact often learns something concerning the nature and place of employment, marital status, number and ages of children, and residence of the contact.

Men are quite reluctant to reveal the name of a married woman for fear of repercussion from the husband, should he learn of his wife's social misbehavior. Therefore, the interviewer expects a certain loss in securing contacts when the suspect is married. It is advisable here to reassure the patient of the privacy of the information he is about to give, and of the very cautious and diplomatic approach used by the contact investigator.

The length of time a patient has known his contact is of considerable importance and lends insight into the validity of other statements. The type of contact may well be anticipated by his information. If a man has known his contact for 6 months and does not know her real name or her address, a married woman who is concealing identity might be suspected.

Closing the Interview

Reemphasize to the patient that he is one of the key people in the venereal disease control program and that the information given in the interview is indeed worth while. Repeat that the contact report is confidential.

The contact investigation form NAVMED-171, provides a single and definite means of identifying and locating an infected person and as such is sufficiently important to warrant more attention than is being given it.

In conferences with public health investigators they point out that the place of employment was almost as important as the girl's name in finding a contact.

The reasons for this are three:

1. The name by which the girl is commonly known is one of any number of nicknames.
2. A full name, if given is usually fictitious.
3. The girl cannot falsify the name of the place in which she is usually seen working.

A number of contact forms with no more information than the place of employment, nickname of the girl, and one or two prominent marks

or scars, bore the notation: "Contact found and under treatment."

Ask yourself.—With the information obtained, would I have a chance of locating the contact?

Remember.—The patient may have had numerous contacts—report them all, from the most recent to the one furthest back in the period of possible exposure. (See exposure chart.)

It seems to be definitely established that a very small number of persons are too intoxicated at the time of exposure to infection to give any information whatsoever which would be a value on a contact report. But this number can in no way account for the extremely high percentage of NAVMED-171's going through with "UNKNOWN" written in practically every space, and with *price paid* at the time of exposure neatly typed in at the bottom of the report. It is illogical to assume that a person will remember nothing whatsoever about his experience but the price he paid. The high percentage of contact reports received with insufficient information to begin investigation can be reduced.

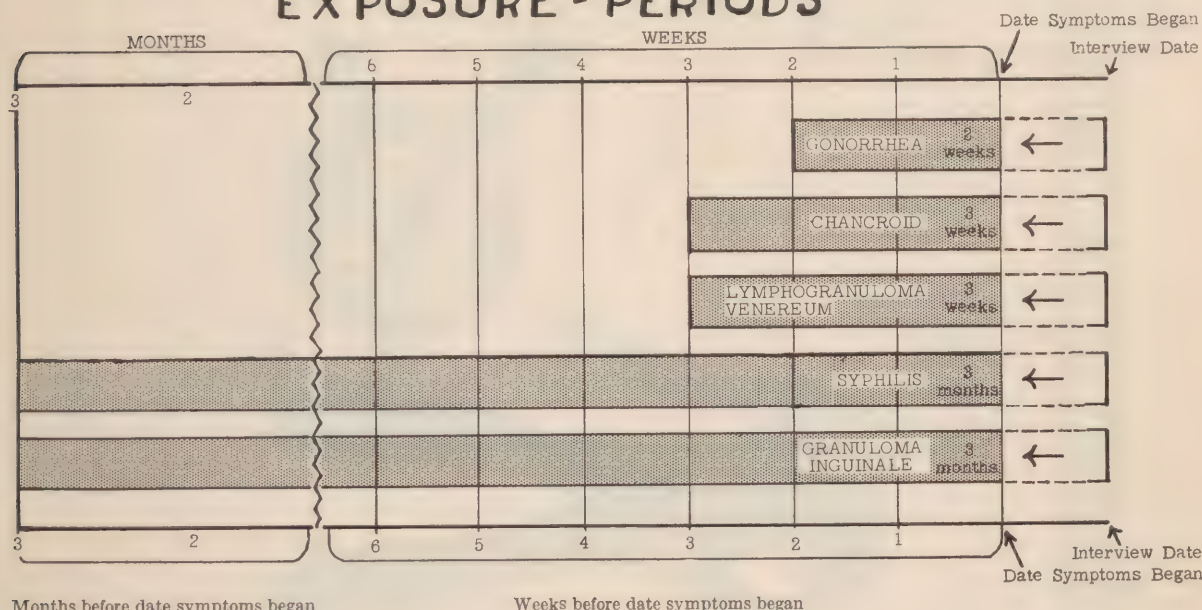
The patient may volunteer to bring in a contact other than his wife, but this practice should be

used with great caution. It is preferable, where the Public Health staff is sufficient for the job, to have the contact located by a third party. In some cases, a man may feel safe in taking an active part in locating a contact, or bringing her to examination. He should be permitted to do so after having the risk to himself explained. A note should be made on Form 171 to the effect that the man will bring the contact to a certain clinic or doctor before a certain date.

Contact Interviewing of Naval Dependents

When marital contacts or other dependents are found to be infected with venereal disease, it is equally important that a thorough contact investigation be done on each such case, and reports on nonservice contacts should be submitted in accordance with local public-health regulations. Whenever the sex or relationship is such that the contact interviewer doubts his ability to obtain a complete contact interview, he should make arrangements with local public-health authorities to provide a civilian contact interviewer.

EXPOSURE - PERIODS



RECORD OF CONTACT INVESTIGATION

1

3 out of 10 cases reported by the Navy are found by civilian investigators.



Of the infectious syphilis cases treated, 1 out of 4 was found by contact investigation.

4

In the Navy, at least 3 contacts per patient are expected; in majority of instances some cases have many more.

3

Better public health clinics obtain 3-4 contacts for each VD patient.

1,000,000

VD cases last year were not reported as found and treated

Some of these People

ARE A POTENTIAL SOURCE OF INFECTION TO OTHERS



BETTER CONTACT REPORTING

- to locate more unreported VD cases and to bring them to treatment.
- protect the individual.
- protect shipmates.

Sequence of the VD Contact and Re-education Interview After Diagnostic Conference Between Medical Officer and Patient

EDUCATION

Stage 1—Preparation	Stage 2—Opening and winning confidence	Stage 3—Education	Stage 4—Spread of the disease
<ol style="list-style-type: none"> 1. Know patient's name. 2. Know which disease the patient has, treatment progress, and needed follow-up. 3. Provide quiet private surroundings, and avoid all interruptions. 	<ol style="list-style-type: none"> 1. Exhibit friendly, sympathetic attitude. 2. Show a genuine and sincere interest. 3. Keep voice low and confidential. 4. Use nickname or first name. 5. Open conversation by some general question about the man and the Navy; age, married, etc. 6. Do not sit at a typewriter or glower at the patient. Use a scratch pad and don't exhibit NavMed-171 now. 7. Be a good listener—allow the patient free expression. 	<ol style="list-style-type: none"> 1. Explain the patient's disease to him in simple terms. Use pictures of male and female G. U. System. 2. Emphasis on: (a) IN FEMALE: (1) Difficulty of diagnosis, (2) she probably doesn't know she has VD, (3) danger if untreated. (b) IN MALE: (1) That disease can be passed on immediately, (2) no discharge necessary for transmission to others. Make this <i>short</i> and show only the Visual Aid which applies to the diagnosis. 	<ol style="list-style-type: none"> 1. Show how disease spreads from woman to man to woman to many more men. 2. Explain how spread can be controlled. Example is useful and important.
		Use Visual Aid Nos. 1 and 2. Use Visual Aid Nos. 4, 5, 6, 7, or 8, depending on patient's diagnosis.	Use Visual Aid No. 3.

CONTACT IDENTIFICATION

Stage 5—VD control	Stage 6—Identification	Stage 7—Closing
<ol style="list-style-type: none"> 1. Why control of spread is important to (a) Navy, (b) shipmates, (c) himself and friends. 2. Show the Navy contact form and explain how it works in conjunction with health department. Point out that patient's name isn't on form. 3. Show how Health Department works with emphasis on: (a) High caliber of health worker, (b) strict confidence of matter and anonymity of patient, (c) no police action, purely a medical problem, (d) tactful approach used by investigators. 	<ol style="list-style-type: none"> 1. Take up 1 girl at a time, beginning with the most recent contact and work back to the beginning of the incubation period as shown by exposure chart. 2. Begin with such questions as (a) "How many girls have you been with in the last — days?" (b) "Were they in this city—(i. e. general area)?" (c) How long have you known them? 3. Then get specific and attempt to identify each contact, starting with place of encounter. 	<ol style="list-style-type: none"> 1. Review the case briefly. 2. Review the patients' knowledge of prophylaxis and re-educate where necessary. 3. Express appreciation for cooperation. 4. Give copies of education material if available. 5. Part with understanding and cordiality.
Exhibit Nav Med-171. Use Visual Aid No. 10.	Use Visual Aid No. 11.	Use Visual Aid No. 9 (prophylaxis).

THE CONTACT REPORT FORM

ROUTING

MEDICAL DEPARTMENT, U. S. NAVY

Venereal Disease Contact Report

Copy A

SERIAL No. 764301

DATE of
REPORT _____For: INVESTIGATING (local) HEALTH DEPARTMENT
of city or county in which exposure occurredREPORTING
STATION _____NAVAL
DISTRICT
NUMBER

(CITY OR COUNTY)

(STATE)

PLACE of
EXPOSURE _____IF SHIP ☐ (check) — BUT DO NOT FILL IN ABOVE.
SEE THIS SPACE ON COPY C.

Date of exposure _____

A MEMBER of The NAVY ☐ (COLOR) (AGE) (SEX) (DISEASE — STAGE)
MARINE CORPS ☐ Under treatment for _____
and whose symptoms began (date) _____ gives the following information:

ALLEGED { (NAME AND/OR NICKNAME) _____
CONTACT { (ADDRESS: ROOM OR APARTMENT NUMBER — NUMBER AND STREET — CITY OR COUNTY — STATE) _____ (PHONE NO.) _____

Color _____ Age _____ Height ☐ (TALL) ☐ (SHORT) ☐ (AVERAGE) ☐ (LIGHT) ☐ (DARK) Other identification (marks, scars, complexion, etc.)
Nationality _____ Build ☐ (THIN) ☐ (FAT) ☐ (MEDIUM) Hair ☐ (RED)

Occupation _____ Employment: Name, type & address _____

Type of contact (PICK-UP, NO FEE) ☐ (FRIEND) ☐ (STREETWALKER) ☐ (HOSTESS, ETC.) ☐ (PROSTITUTE) ☐ (OTHER) _____

PLACE of ENCOUNTER (TAVERN, BAR, ETC.) ☐ (STREET) ☐ (HOTEL) ☐ (HOME, APT.) ☐ (BUS OR RR STATION) ☐ (DANCE HALL) ☐ (PARK) ☐ (TAXI) ☐ (OTHER) _____

Name and Address _____ Solicitation by contact? (YES) ☐ (NO) ☐

Procured by (OWN EFFORT) ☐ (PIMP) ☐ (CAB DRIVER) ☐ (BELLHOP) ☐ (WAITER) ☐ (OTHER) _____

Name, description, address of procurer _____

PLACE of EXPOSURE (HOTEL) ☐ (HOME OR APARTMENT) ☐ (TAXI) ☐ (AUTO) ☐ (PARK) ☐ (TOURIST CAMP) ☐ (BROTHEL) ☐ (STREET) ☐ (OTHER) _____

Name and Address _____

FEE PAID \$ _____ Paid (CONTACT) ☐ (PROCURER) ☐ (OTHER) ☐ Estimated amount spent on contact for food, drinks, room, etc. (not including fee) \$ _____
PROPHYLAXIS (NONE) ☐ (CONDOM) ☐ (STATION) ☐ (NAVY TUBE) ☐ (other — specify type, brand, etc.) _____ (comments - time interval) _____

REMARKS _____

Investigating health department: Please report the results of your contact investigation on the reverse side of the ACTION-RETURN copy B of this form.

Signed _____ MC _____ USN _____

WAS THIS THE ONLY POSSIBLE CONTACT DURING THE PATIENT'S PERIOD OF INFECTIOUSNESS?
Report each contact on a separate form. Make at least one report for each case.

INSTRUCTIONS FOR REPORTING NAVY MEDICAL OFFICER

1. Tear sheets off in units of 5 (copies A, B, C, D, E). Be sure each of the five sheets carries the same printed serial number. Use typewriter. If a form is mutilated, **destroy and use a new set**. Never change the serial number.
2. Give all possible information, but submit reports even if incomplete. Make at least one report for each original admission and E.P.T.E. Submit a separate report for each contact. Enter on the Form F Card (remarks) of each case the serial number of each contact report.
3. If the ship or station reporting is **within** the geographic boundaries of a Naval District or River Command, all report copies except your file copy E are to be sent to that D. M. O. or S. M. O. . . .
 - (a) — Unless the place of exposure is nearby and you know the exact health department to which it should be sent for prompt and effective action. If so, forward copies A and B to the investigating health department; copy C to the D. M. O. or S. M. O.; copy D to state health department.
 - (b) — Unless the D. M. O. or S. M. O. of the area in which you are located has given other orders.
4. If the ship or station reporting is **not within** the boundaries of a Naval District or River Command, retain your file copy E and . . .
 - (a) — If the exposure took place in a District or River Command, forward copies A, B, C, D to that D. M. O. or S. M. O.
 - (b) — If the exposure did not take place in a District or River Command, forward copies A, B, C, D to the Bureau of Medicine and Surgery, unless the appropriate Fleet or independent command Senior Medical Officer has given other orders.
5. Marital contacts of Naval patients, and reports naming as contacts any members of the armed services, will be handled in accordance with instructions of the Bureau of Medicine and Surgery.

FORWARD EACH CONTACT REPORT FOR ACTION AT THE EARLIEST PRACTICABLE MOMENT.

RESULT OF VENEREAL DISEASE CONTACT INVESTIGATION BY HEALTH DEPARTMENT*

From _____

To: REPORTING SHIP OR STATION, U. S. NAVY *
via (1) State health department; (2) District Medical Officer of
Naval District in which the state is located.

Data furnished insufficient to begin investigation ☐

The alleged contact described on reverse was:

Infected with _____

Under treatment: Prior to this investigation ☐ As a result of this investigation ☐

Examined and found not infected ☐

Found but not examined ☐ Reason _____
(insufficient data) (moved) (other)

Unsuccessful Investigation ☐ Reason ☐ ☐

NOTE: If no results have been obtained within six weeks from date of report (see other side, top left corner), and no further action is anticipated, please sign and return report.

Remarks _____

DATE _____

RETURNED _____ SIGNED _____

Title _____ M. D.

SPECIAL NOTE — Copy B is the ACTION and RETURN copy. Local (investigating) health departments are requested to forward a report of their investigation on Copy B via their state health department. If desired, investigation report data may be transcribed by the state to its file copy D. The state health department is requested to then forward copy B to the District Medical Officer of the Naval District (or the Senior Medical Officer of the River Command) in which the state is located.

Basic "Instructions for Reporting Navy Medical Officer" as printed on the reverse of Form NavMed 171 are reproduced below with supplementary details and instructions, and with special reference to administration of the system by District and River Command Medical Officers:

1. Tear sheets off in units of 5 (copies A, B, C, D, E). Be sure each of the five sheets carries the same printed serial number. Use typewriter. If a form is mutilated, destroy and use a new set. Never change the serial number.

Serial numbers are for identification only. It is not necessary that reports be handled in any numerical sequence.

2. Give all possible information, but submit reports even if incomplete. Make at least one report for each original admission and E.P.T.E. Submit a separate report for each contact. Enter on the Form F Card (remarks) of each case the serial number of each contact report and the place(s) of exposure.

It is of fundamental importance that every patient be interviewed in an effort to determine the possible source of his infection and to identify others who may have been exposed to his infection. Except in extraordinary cases it should be possible to obtain information about at least one and frequently other contacts. Special attention is directed to Ref (b). Contact reports of "Diagnosis Undetermined" cases should be submitted when the diagnosis is established.

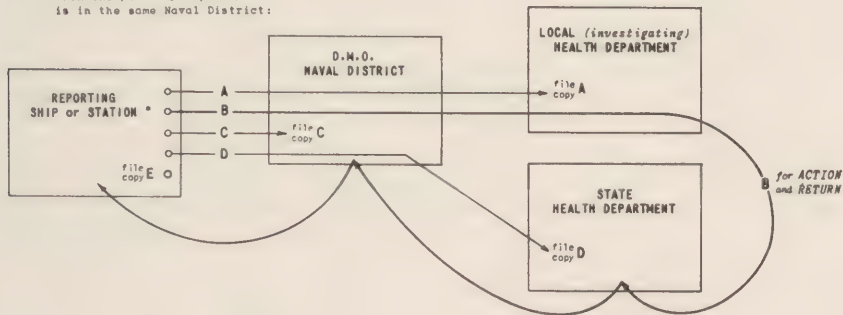
3. If the ship or station reporting is within the geographic boundaries of a Naval District or River Command, all report copies except your file copy E are to be sent to that D. M. O. or S. M. O. . . .

ANY contact report made by a ship or station within the area of a Naval District or River Command can be routed directly to that D.M.O. or that River Command S.M.O. Further action is determined by the place of exposure, as follows:

NOTE: In all charts, the rectangle labeled "D.M.O. NAVAL DISTRICT" refers both to Districts and River Commands.

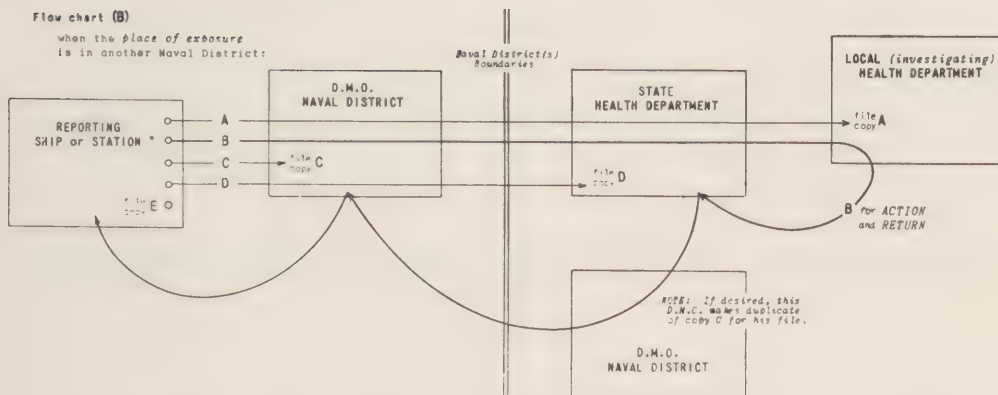
Flow chart (A)

when the place of exposure
is in the same Naval District:



Flow chart (B)

when the place of exposure
is in another Naval District:



* Reporting activity is within the area of a Naval District or River Command.

Flow chart (C)

when the *place of exposure*
is in a foreign country:

The reporting ship or station *
retains copy E, forwards copies
A,B,C,D to the D.M.O.

The D.M.O. retains copy C, for-
wards copies A,B,D to the Bur-
eau of Medicine and Surgery un-
less special follow-up arrange-
ments are made as outlined in
4(b), below.

It should be noted that, in general, routing of reports is indicated by the printed address at the top right of each copy of the report form. See comments below for Instruction 3(b) as to whether reports should be sent to local or state health departments.

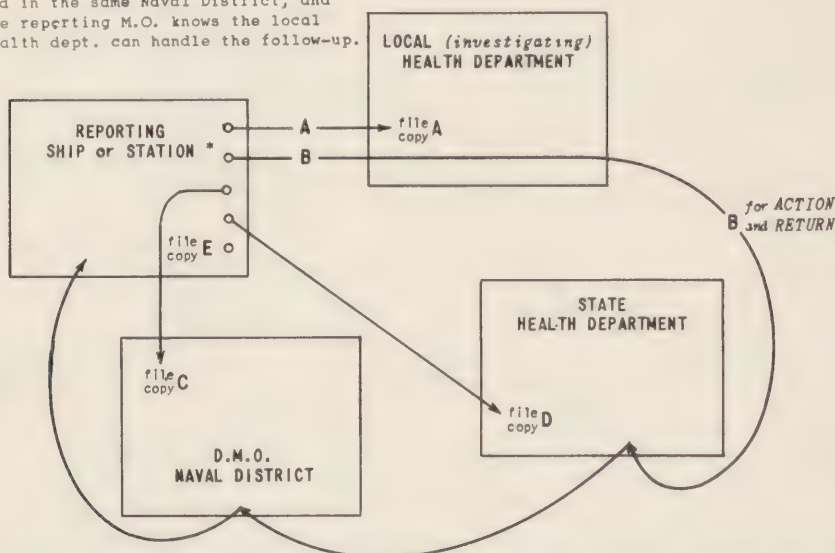
Basic Instruction 3 (above) applies . . .

(a) — Unless the place of exposure is nearby and you know the exact health department to which it should be sent for prompt and effective action. If so, forward copies A and B to the investigating health department; copy C to the D. M. O. or S. M. O. ; copy D to state health department.

Speed is essential in tracing contacts. Whenever possible reporting ships and stations should forward reports as indicated by Instruction 3(a) when the place of exposure is within the same Naval District or River Command as the reporting ship or station. The flow of reports is as follows:

Flow chart (D)

when the *place of exposure* is nearby
and in the same Naval District, and
the reporting M.O. knows the local
health dept. can handle the follow-up.



* Reporting activity is within the area of a Naval District or River Command.

Instructions 3 and 3(a) apply . . .

(b) — *Unless the D. M. O. or S. M. O. of the area in which you are located has given other orders.*

It is the responsibility of each D.M.O. and River Command S.M.O. to issue such supplementary instructions relative to routing and handling of contact reports as may be necessary to meet special conditions. He should be informed of the policy of state health departments in his District or Command regarding the handling of contact reports by civilian health agencies -- i.e., whether reports should be sent to local health departments (if so, which ones) or to the state health department for follow-up investigation. This information should be available to all ships and stations in the District or River Command.

In the interests of speed, instructions may also be issued to reporting stations to forward out-of-District reports directly to larger cities or to state health departments which are equipped to efficiently handle contact reports. Section IV of this outline lists U.S. Public Health Service District Directors who have been designated to provide liaison between civilian and naval authorities and who are prepared to confer with each D.M.O. and River Command S.M.O. in the clarification of such details.

4. If the ship or station reporting is *not* within the boundaries of a Naval District or River Command, retain your file copy E and.
- (a) — *If the exposure took place in a District or River Command, forward copies A, B, C, D to that D. M. O. or S. M. O.*

In such cases, the action of the D.M.O. or S.M.O. is identical with that described in Flow Chart (A).

- (b) — *If the exposure did not take place in a District or River Command, forward copies A, B, C, D to the Bureau of Medicine and Surgery, unless the appropriate Fleet or independent command Senior Medical Officer has given other orders.*

Normally the Bureau of Medicine and Surgery, rather than District or River Command Medical Officers, will handle foreign contact reports. In certain cases, however, it may be possible and advantageous to make local arrangements to follow-up contacts. This will usually require the existence of reasonably efficient and cooperative civilian health agencies. Only in rare instances should the Medical Department of the Navy undertake such responsibilities.

Special foreign follow-up arrangements should only be made by the D.M.O., the F.M.O., or the independent overseas command S.M.O., or by specific authority of such officers or BuMed. Any arrangements must be reported officially to BuMed. Where foreign local follow-up is established, copy C is to be forwarded to BuMed for statistical analysis as outlined in Section VI.

5. Familial contacts of Naval patients, and reports naming as contacts any members of the armed services, will *not* be reported to civilian health authorities. *Handle in accordance with existing instructions of the Bureau of Medicine and Surgery**

FORWARD EACH CONTACT REPORT FOR ACTION AT THE EARLIEST PRACTICABLE MOMENT.

Supplementary instructions to reporting ships and stations should emphasize the importance of (1) completing at least one report for each patient, giving as much information as possible, but forwarding even if incomplete; (2) forwarding reports immediately upon completion to permit prompt follow-up action; and (3) making a separate report for every possible contact during the patient's period of infectiousness.

** However, they will be reported to local health authorities if they, (a) fail to report for examination at a naval activity, or present evidence that they have been examined by a civilian doctor; or (b) they lapse treatment.*

Basic "Result of Venereal Disease Contact Investigation by Health Department" instructions as related to the duties of Naval District and River Command Medical Officers:

Routing of the health department report of investigation is indicated both on the reverse of NavMed 171 and by Flow Charts (A), (B), and (D). Attention is directed to . . .

SPECIAL NOTE -- Copy B is the *ACTION and RETURN* copy. Local (investigating) health departments are requested to forward a report of their investigation on copy B via their state health department. If desired, investigation report data may be transcribed by the state to its file copy D. The state health department is requested to then forward copy B to the District Medical Officer of the Naval District (or the Senior Medical Officer of the River Command) in which the state is located.

When the place of exposure and the reporting activity are both in the same Naval District or River Command, that D.M.O. or S.M.O. transfers data given on the health department report blank of copy B to his file copy C and returns copy B to the originating station. Since security precludes ship addresses, copy B can not be returned to ships. It should be disposed of as desired.

When the place of exposure and the reporting activity are in different Naval Districts or River Commands, the D.M.O. or the S.M.O. of the area in which the exposure took place may, if he wishes, make for his files a copy of the report using a blank Form NavMed 171 the serial number of which has been cancelled and the copy B serial number substituted. The Action and Return copy B is then forwarded (see Flow Chart (B)) to the D.M.O. or S.M.O. of the area in which the originating activity is located. Here the D.M.O. or S.M.O. transcribes the report data to his copy C and returns copy B to the originating station.

It should be noted that the Action and Return copy B is invariably returned (1) by the investigating health agency to its own state health department (the investigating health agency may be, of course, the state health department itself); (2) by the state health department to the Naval District or River Command in which the state is located. When the originating station is not within the District or River Command in which the state is located, that D.M.O. or S.M.O. forwards the report to the originating area as outlined in the preceding paragraph.

Attention is directed to . . .

NOTE: *If no results have been obtained within six weeks from date of report (see other side, top left corner), and no further action is anticipated, please sign and return report.*

A period of eight weeks is considered ample time to carry out the epidemiological process. Contact reports, particularly in the case of gonococcal infection, unless followed-up within this period of time, may be considered virtually useless. It is recommended that the D.M.O. or River Command S.M.O., therefore, query investigating health departments which are consistently delinquent, stressing the importance of prompt epidemiological action in the interests of venereal disease control in the Navy.

U. S. Public Health Service Cooperation:

This standardized system of contact reporting has been developed with the cooperation of the Surgeon General of the U.S. Public Health Service, who has informed state health officers of the details and has recommended that state and local health authorities cooperate fully. The Conference of State and Territorial Health Officers has approved the system.

Public health practice and legislation vary from state to state relative to handling of contact investigations. As noted in Section II under Instruction 3(b) it will be necessary for each D.M.O. and the S.M.O. of each River Command to adjust the overall system to meet specific conditions without, however, modifying the basic

outlines of the plan. To provide a liaison with state and local health authorities the Surgeon General of the U.S. Public Health Service has designated his District Directors to cooperate with each District and River Command Medical Officer in such ways as may be appropriate.

Part II

Visual Aids

The purpose of the venereal disease visual aids is to assist the interviewer in interpreting the facts of venereal disease to the patient. Full-page photos and diagrammatic views of each of the venereal diseases are presented, showing the causative organism and various stages and effects of the diseases. Each disease is described, giving symptoms, its diagnosis, treatment, and spread. It is not intended that the visual-aids section be shown to a patient without discussion and explanation by the interviewer.

The interviewer can use the visual-aids section in present form and sequence, always selecting of course, those pages applicable to each particular patient. Or, the interviewer can substitute or add other pictures of his own selection.

The alert interviewer employs visual aids to keep the interview moving, to interpret educational data, and to demonstrate the patient's role in contact investigation. Further, he takes advantage of the potentialities of these instruments to increase participation of the patient in the interview by encouraging him to explain and interpret their implications and by relating the patient to them.

Visual Aid No. 1.—Side view of male organs.

Visual Aid No. 2.—Side view of female organs.

Visual Aid No. 3 (how VD spreads).—A photodiagrammatic presentation showing how VD

spreads and an actual presentation of a localized outbreak of syphilis.

Visual Aid No. 4 (syphilis).—Two pages showing the causative organisms, effects of untreated syphilis, and photographs of various stages.

Visual Aid No. 5 (gonorrhea).—Two pages showing gonorrhea in the male and female with causative organism and effects if untreated.

Visual Aid No. 6 (chancroid).—A photodiagrammatic view of the causative organism and typical physical signs.

Visual Aid No. 7 (granuloma inguinale).—A photodiagrammatic view of the causative organism and typical physical signs.

Visual Aid No. 8 (lymphogranuloma venereum).—A photodiagrammatic view of a microscopic field indicating the causative organism is too small to be seen. Photos of lesions.

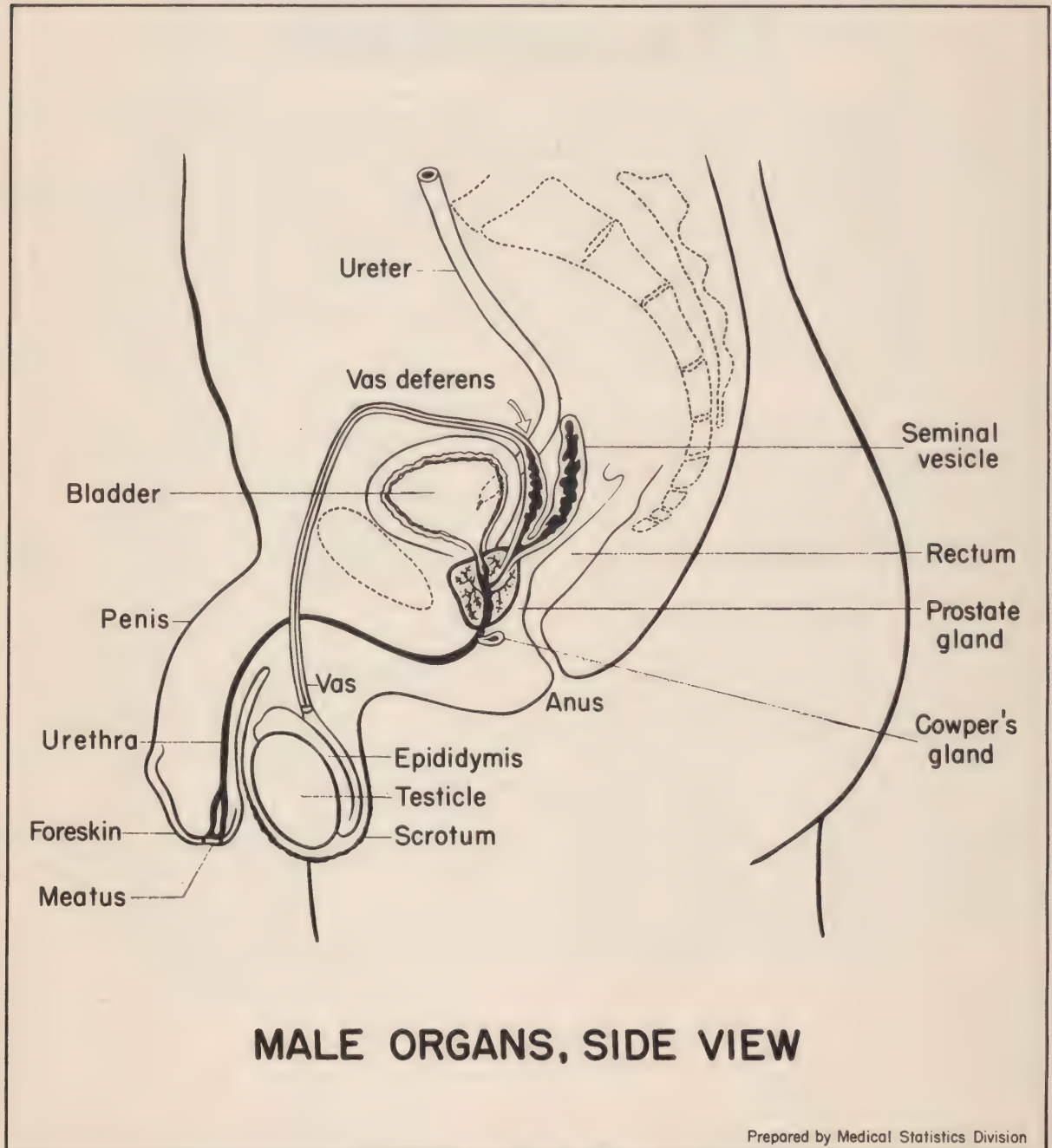
Visual Aid No. 9 (Prophylaxis).—Photographs and diagrams showing the methods of (a) Mechanical, (b) Pro-tube, and (c) Station prophylaxis.

Visual Aid No. 10 (location of VD contacts).—A pictograph lay-out showing the normal steps in contact investigation.

Visual Aid No. 11 (where can she be found).—Street grids, showing various types of streets, may be used to reorient patient as to place of procurement and place of exposure of contact.

The sex organs of the male are partly on the outside and partly on the inside of the body. The parts which are visible from the outside are the penis and the scrotum. Inside the scrotum are the testicles and the epididymis. The testicle is the complicated mechanism in which the life-giving sex cells are produced. When these cells mature they pass into the coils of the epididymis

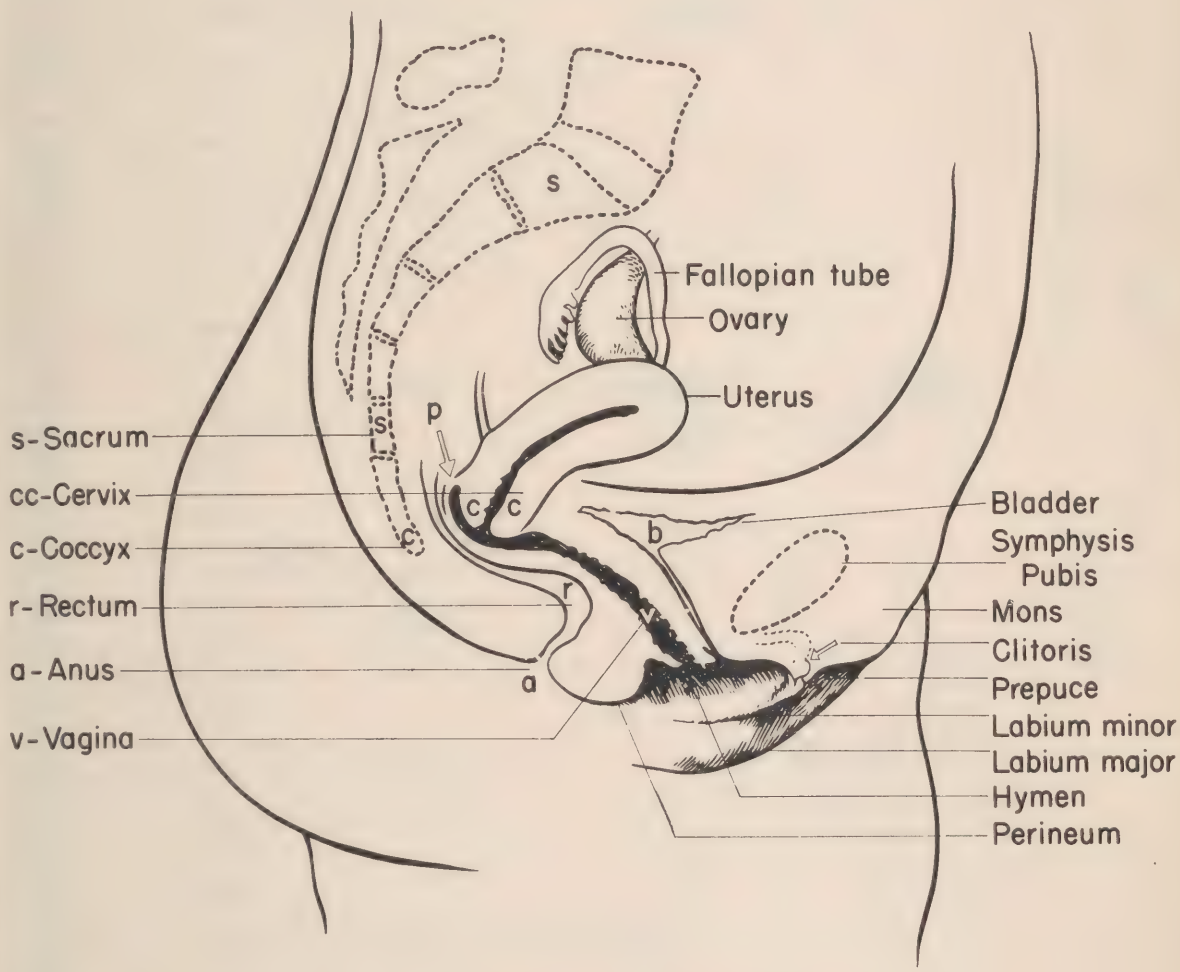
where they further develop. They then pass through the spermatic cord up into the seminal vesicles inside the abdominal cavity. Here they are stored until discharged through the urethra, along with secretions from the seminal vesicles themselves and from the prostate gland. If any of the organs become diseased, the whole complicated system may be disturbed.



VISUAL AID NO. 1

The female organs are almost entirely within the body. The principal parts which are visible from the outside are the labia. These surround the opening of the vagina, which is a passage made up of many folds of mucous tissue which gives considerable elasticity. At the innermost part of the vagina is the cervix which is the mouth of the uterus (womb). The uterus is a pear-

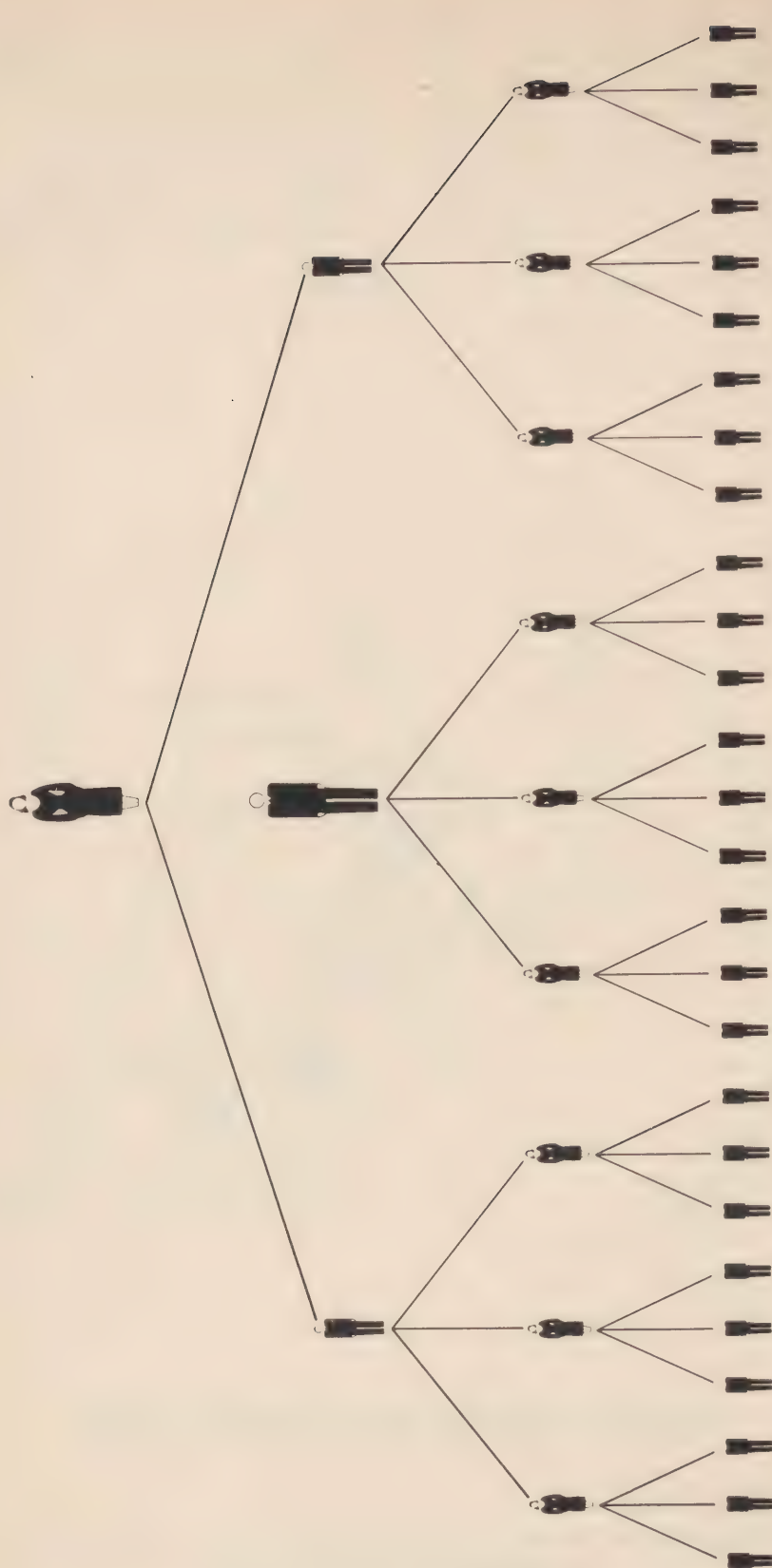
shaped organ composed of interlacing muscle fibers with a special glandular membrane lining. From each side of the top of the uterus extend two passageways known as the Fallopian tubes which connect with the ovaries. Notice that the bladder is located in front of the uterus and that the urinary tract is not as intimately connected with the sex apparatus as is the case in the male.



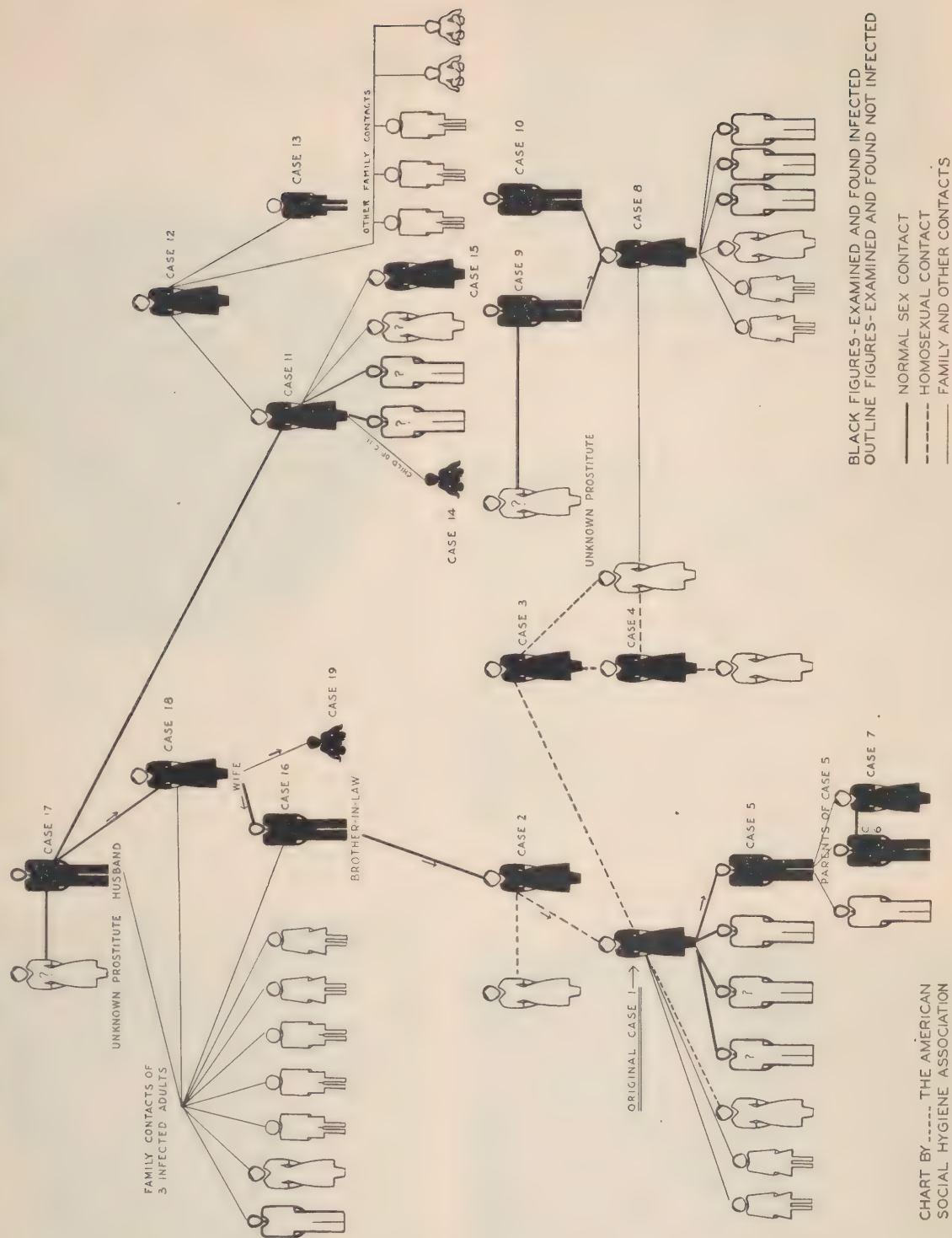
FEMALE ORGANS, SIDE VIEW

Prepared by Medical Statistics Division

VISUAL AID NO. 13
HOW VD SPREADS



INVESTIGATION OF A LOCALIZED OUTBREAK OF SYPHILIS



Syphilis

Common Names or Synonyms:

"Syph," "pox," "lues," "Old Joe," "bad blood,"
"Hard chancre," "chancre."

Germ Causing Disease:

Treponema pallidum (popular term, "spirochete").

Method of Spread:

1. Usually sexual intercourse.
2. Kissing and fondling.
3. Prenatal (mother to fetus).

Incubation Period:

10 to 90 days.

Clinical Signs and Symptoms:

Early:

Primary chancre.

Secondary rash, mucous patches, sore throat,
headaches, fever, etc.

Latent (early latent; late latent). (Seropositive only.)

No active manifestations.

Late (tertiary):

Active manifestations: Cardiovascular, neuro-
syphilis, gumma, ocular, osseous, visceral.

Mucocutaneous relapse:

Recurrence of infectious lesions after disappear-
ance of secondary lesions.

Diagnosis:

Darkfield examination (laboratory tests).

Serological tests.

Spinal fluid.

Case history.

Clinical signs and symptoms.

X-ray.

Treatment:

Penicillin.

Arsenicals.

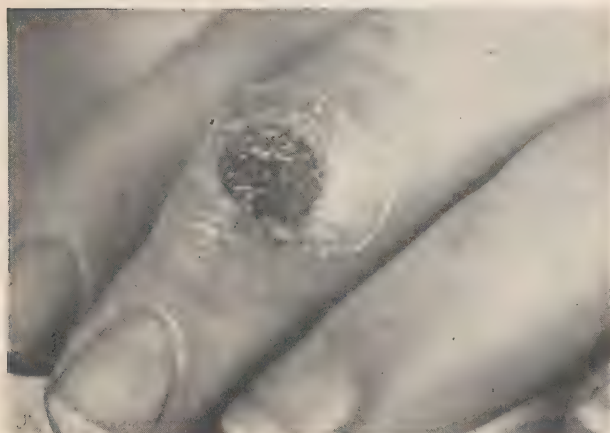
Heavy metals (bismuth).

Combination of arsenicals and heavy metals, or all
three.

VISUAL AID NO. 4



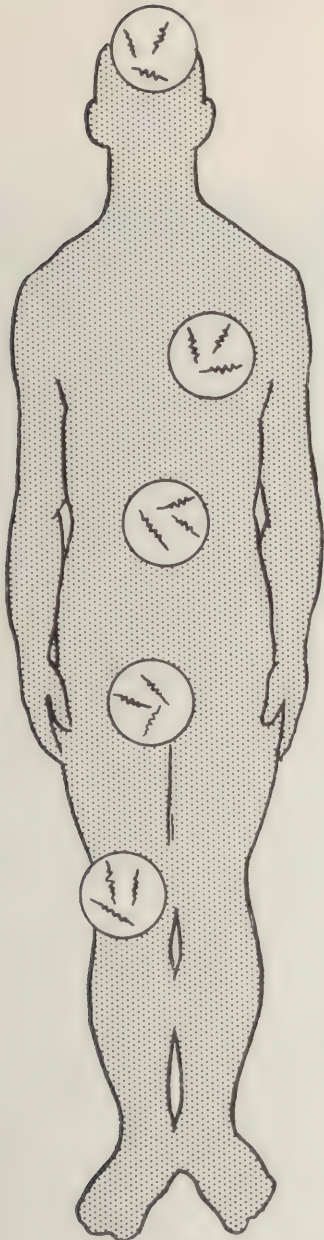
Microscopic view of spirochete.



Early syphilis—chancre on finger.



Early syphilis—healing primary chancre of 5 weeks' duration on glans penis. Symptoms of secondary syphilis had already appeared.



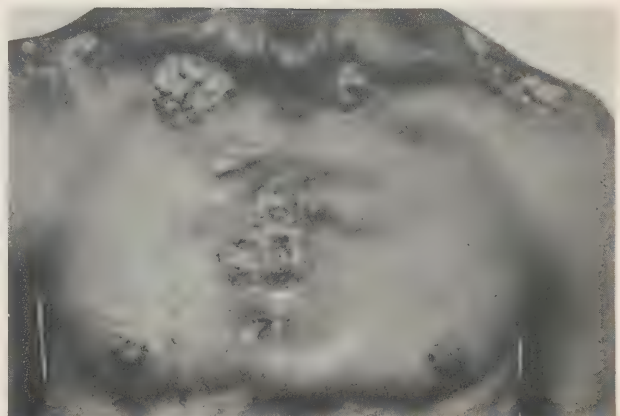
Untreated syphilis can affect these areas—eyes, ears, brain, spine, nerves, heart, lungs, skin, stomach, liver, bones.



Secondary syphilis—lesion of 1 week's duration on lower lip. Patient also had gonorrhea.



Syphilis secondary.



Late syphilis—multiple gummata of chest.

Gonorrhea

Common Names or Synonyms:

"Clap," "dose," "strain," "the drip," "running,"
"gleet," "GC."

Germ Causing Disease:

Neisseria gonorrhea (gonococcus).

Methods of Spread:

Sexual intercourse and ophthalmia, infection at birth.

Incubation Period:

3 to 14 days.

Clinical Signs and Symptoms:

Male:

Purulent urethral discharge. Burning on urination. Pain (sometimes). Inflammation and swelling.

Female:

Possibly, no symptoms. Vaginal discharges. Pain in abdomen (when salpingitis occurs).

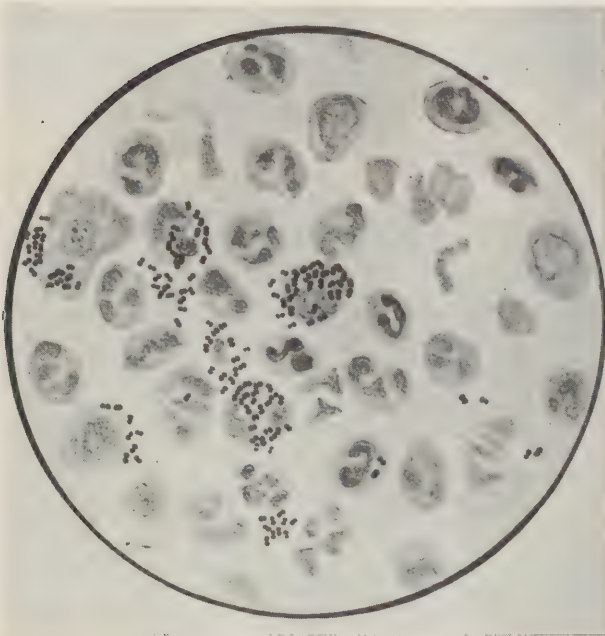
Diagnosis:

Smears.
Cultures.
Case history.
Clinical signs and symptoms.

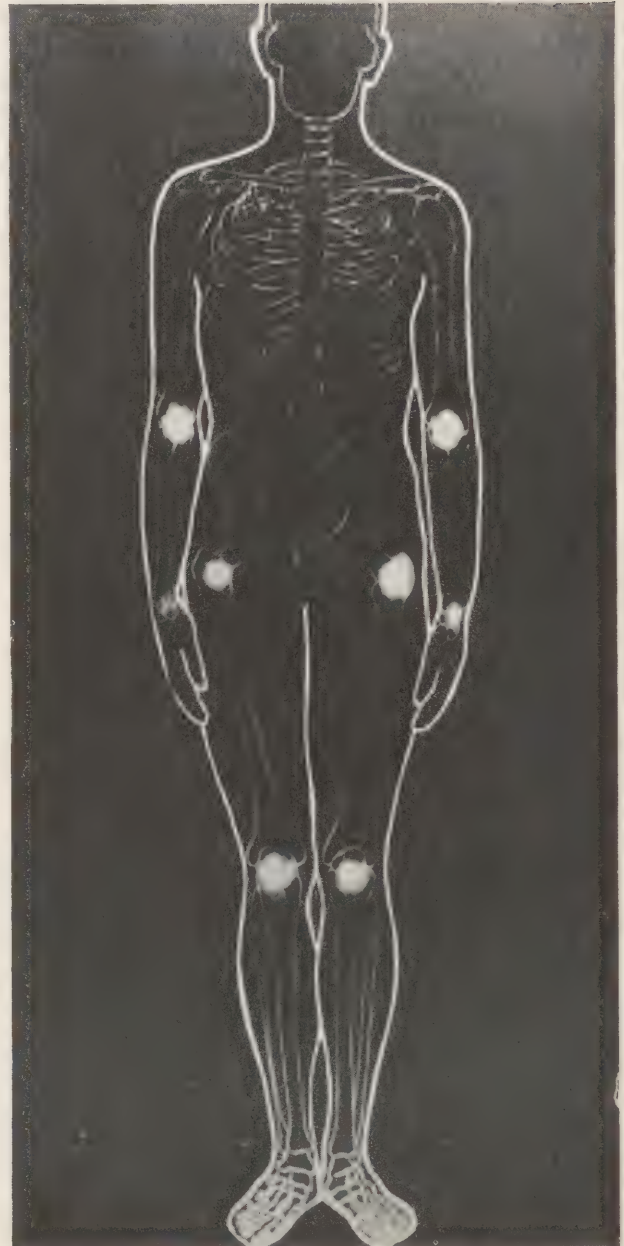
Treatment:

Penicillin.
Sulfonamides.
Combination of penicillin and sulfonamides.

VISUAL AID NO. 5

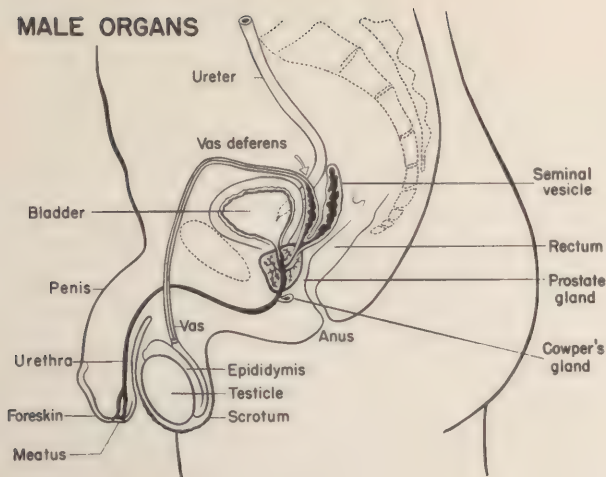


Microscopic view of gonococci.

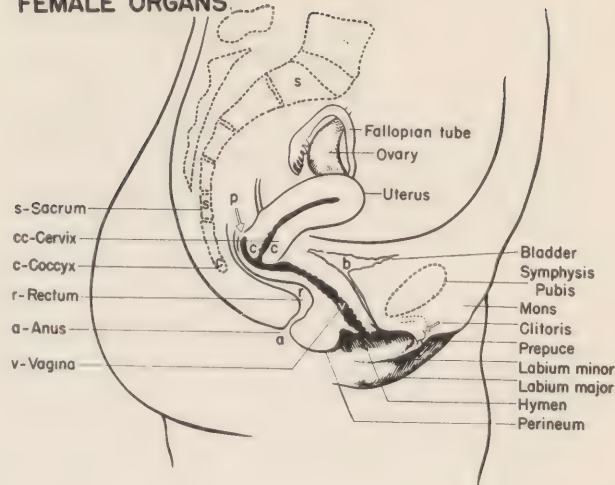


Untreated gonorrhea may attack any or all of these locations. It may cause sterility (inability to have children), blindness and arthritis.

MALE ORGANS



FEMALE ORGANS



Untreated Gonorrhea may cause sterility (inability to have children), blindness, arthritis, and serious surgical operations.

Gonorrhea is not as easily recognized in a woman as in a man—not only because the germs may lodge

in so many different places—but also because the woman may think the discharge is some other trouble, or she may not even notice any unusual discharge.



Swollen fallopian tubes caused by gonorrhea. Gonnorrhea inflammation in the neck of the uterus.

Chancroid

Common Names or Synonyms:

"Soft chancre," "bubo," "hair cut."

Germ Causing Disease:

Ducrey bacillus.

Method of Spread:

Sexual intercourse.

Incubation Period:

2 to 12 days.

Clinical Signs and Symptoms:

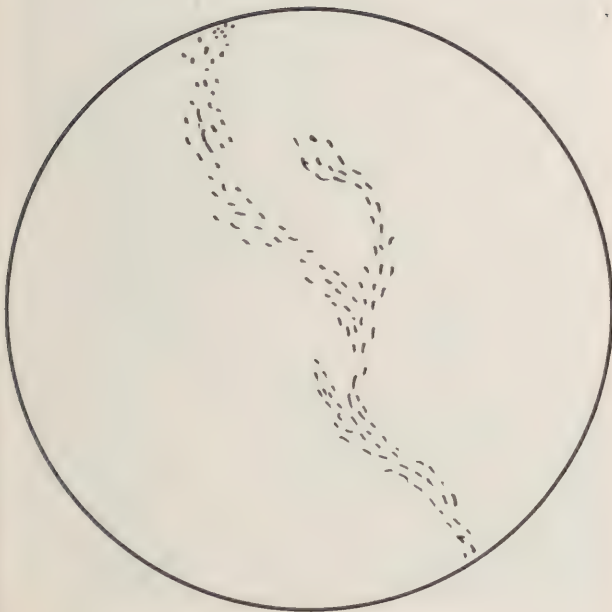
Frequently multiple or single, painful, tender, rapidly growing, nonindurated ulceration, with undermined border, ragged edge, and dirty gray wet base. Tender swollen lymph glands in groin, (buboes).

Diagnosis:

Darkfield (to exclude syphilis).
Skin test (Ito-Reenstierna).
Presence of Ducrey bacillus.
Case history.
Clinical signs and symptoms.

Treatment:

Sulfonamides.
Cleanliness.
Hot soaks



Microscopic view of Ducrey bacillus.



Chancroid in male with fluctuating inguinal bubo.

Granuloma Inguinale

Common Names or Synonyms:

"Ulcerative granuloma of pudenda."

Germ Causing Disease:

Donovan bodies.

Method of Spread:

Sexual intercourse.

Direct contact by skin and mucous membrane.

Incubation Period:

2 to 12 weeks.

Clinical Signs and Symptoms:

Beefy, red, granular, shiny, well defined, granulating ulcer, slowly growing but progressive.

Diagnosis:

Darkfield (to exclude syphilis). Case history.

Clinical signs and symptoms.

Presence of Donovan bodies.

Treatment:

Streptomycin.

Tartar emetic, fuadin, etc., intravenously.

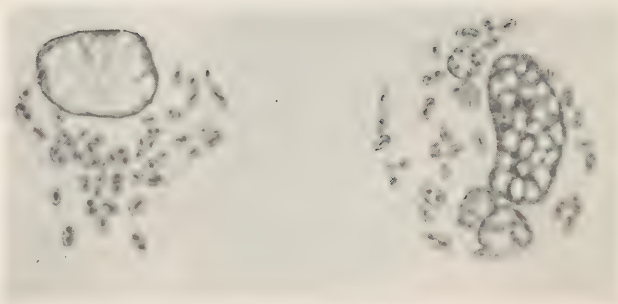
Cleanliness.

Surgery.

X-ray.



Granuloma inguinale of penis. Biopsy showed sub-acute granuloma.



Microscopic view of the Donovan bodies. Note encapsulated Donovan bodies escaping from cell. Granuloma inguinale of penis. Biopsy showed sub-acute granuloma.

Lymphogranuloma Venereum

Common Names or Synonyms:

"Lymphopathia venereum," "lymphogranuloma inguinale."

Germ Causing Disease:

A specific filterable virus.

Method of Spread:

Sexual intercourse.

Direct contact by skin and mucous membrane.

Incubation Period:

10 to 30 days.

Clinical Signs and Symptoms:

Frequently absent history or presence of a pimple or small ulceration in about one-third of the cases.

Buboes.

Rectal stricture in late stage in female.

Diagnosis:

Darkfield (to exclude syphilis).

Case history.

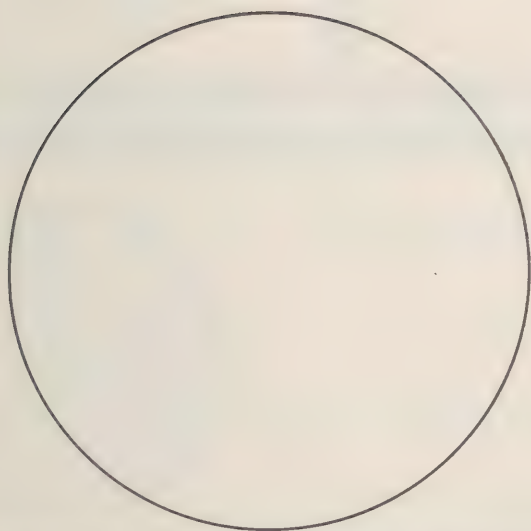
Clinical signs and symptoms.

Frei skin test.

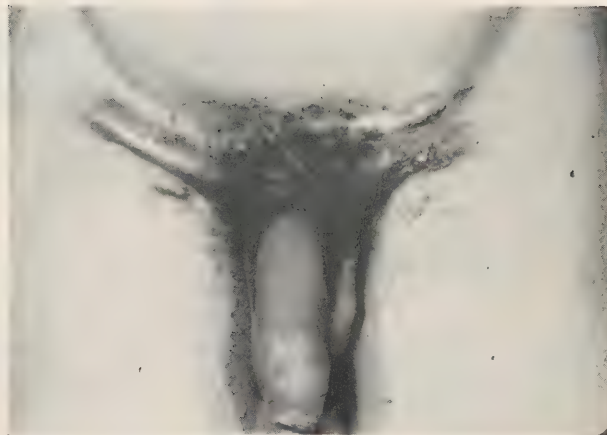
Treatment:

Sulfonamides.

Dilation of rectal stricture.



The causative agent is a "virus" which is too small to be seen even under a powerful microscope.



Lymphogranuloma Venereum in male. Bilateral lymphadenitis with sinus formation. Lymph nodes lying below Poupart's ligament. Patient also had early latent syphilis and chancroid.

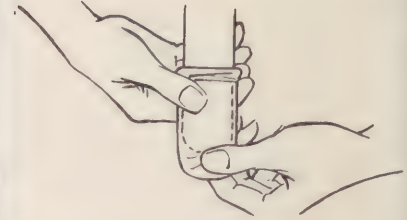
PROPHYLAXIS

1

THE CONDOM



The condom should be tested
before use



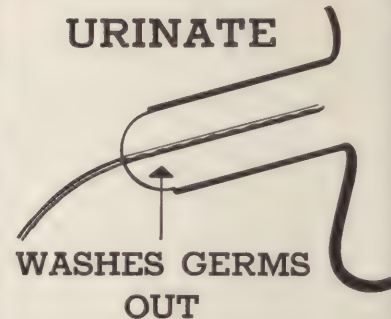
Put the condom on early—
no sexual contact should be made
before the condom is put on

2

THE NAVY TUBE



URINATE



WASHES GERMS
OUT

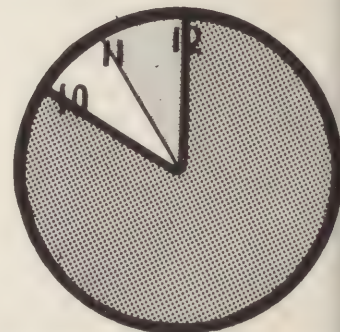
3

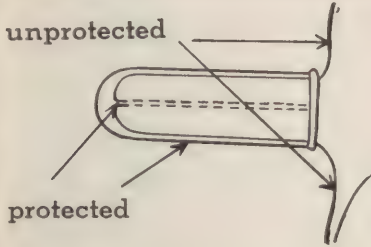
THE "PRO" STATION

"PRO" STATION

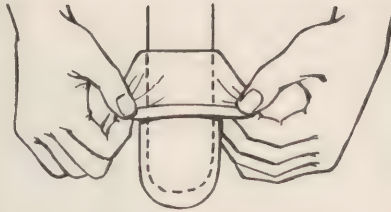
Go immediately
or within 1 to 2 hours
on ship or shore

NAVY OR ARMY STATIONS





Put the condom on carefully—
don't try to do it in the dark

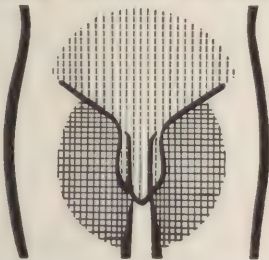


Remove the condom carefully—
the outside may have germs on it

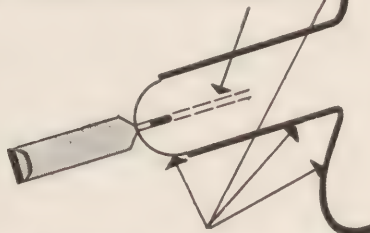
**PROPHYLAXIS
PREVENTS**

VD

**WASH WITH
SOAP AND WATER**



**SQUEEZE ½ CONTENTS
OF TUBE INTO CANAL**



**RUB REST OF OINTMENT
IN FOR 5 MINUTES**

A complete chemical prophylaxis can be obtained at Navy or Army prophylactic stations ashore, or in the sick bay. "Pro" stations are under the direction of medical officers. Trained hospital corpsmen supervise prophylaxis. Names are not taken.

Station prophylaxis is almost 100 percent sure if taken within 2 hours after exposure.

Even if a condom and a tube prophylaxis are used, it is safer to go to the "pro" station. Try to get there within 2 hours. Never wait longer than 8 or 12 hours. The sooner you go the better are your chances of NOT getting infected.

Cleanliness is very important. Everytime you bathe or take a shower, pull back the foreskin of the penis and wash underneath it.

Many infections can be prevented by certain measures BEFORE and AFTER sexual exposure. The medical name of these measures is PROPHYLAXIS. Prophylaxis means guarding yourself and your service against disease.

Prophylaxis consists of using a condom during the sex act and chemicals after the act. The condom protects both the man and the woman. Chemicals protect only the man. The condom acts as a shield which keeps the germs from being passed from one person to another. It is safer, therefore, to rely on the condom first and use chemicals as an added precaution.

Remember—7 out of 10 sailors and marines with venereal disease DID NOT USE PROPHYLAXIS.

It doesn't pay to take a chance.

Venereal disease is bad for you and it's bad for the Navy.

Venereal disease can be avoided by avoiding sexual exposure.

Prostitutes and pick-ups are dangerous. **WATCH YOUR STEP.**

Location of VD Contacts



1. Interview of Navy patient and reporting contacts to the Public Health.



2. Public Health officer turns contact report over to field worker.

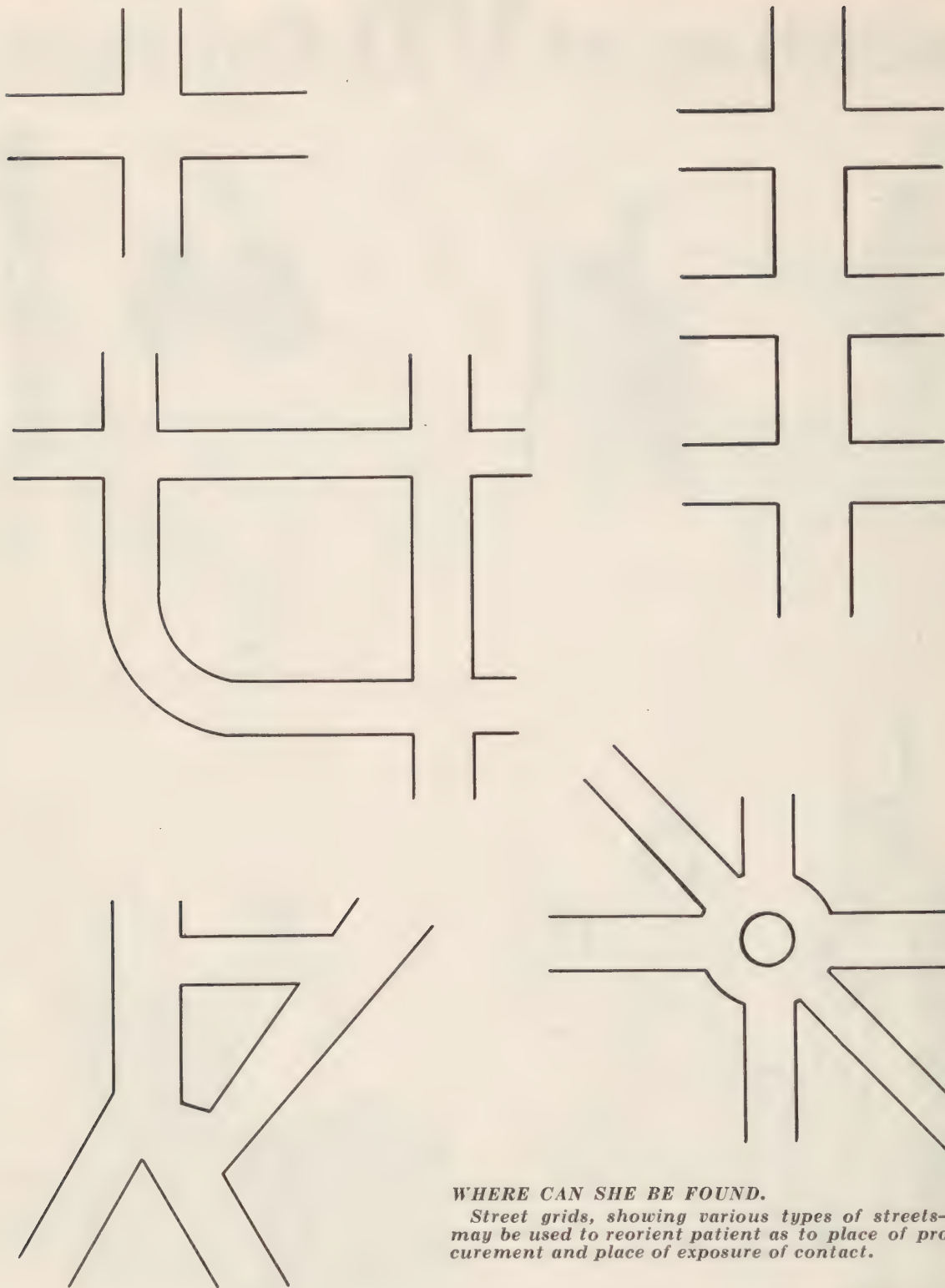


3. Field worker locates contact.



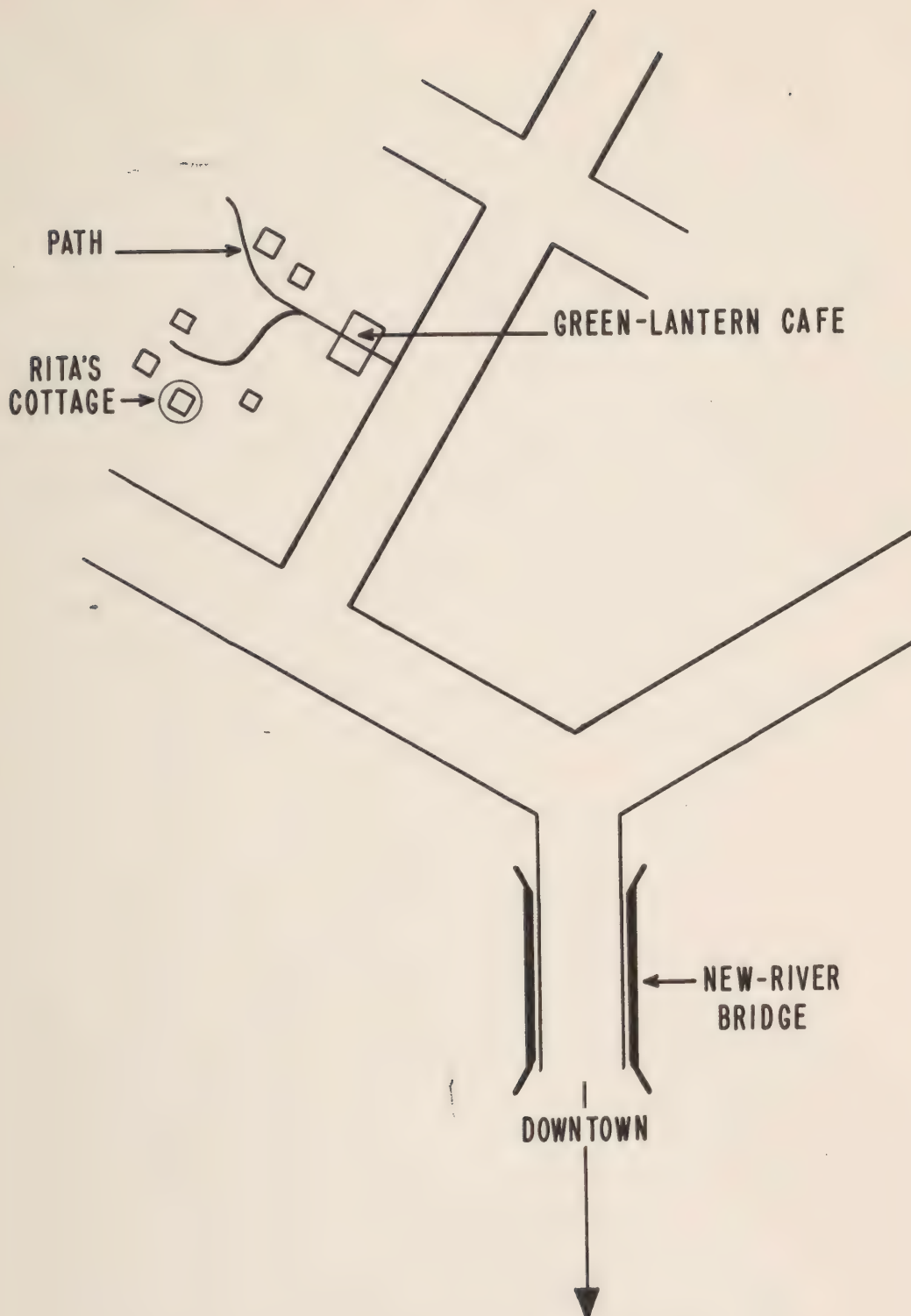
4. Contact is examined by a physician.

Visual Aid No. 11



WHERE CAN SHE BE FOUND.

Street grids, showing various types of streets—may be used to reorient patient as to place of procurement and place of exposure of contact.



An example of diagram prepared to assist the contact investigator.

PRESSBOARD
PAMPHLET BINDER



Manufactured by
GAYLORD BROS. Inc.
Syracuse, N. Y.
Stockton, Calif.

WC 142 qU58i 1948

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